



Department of Obstetrics & Gynecology
 Maternal-Fetal Medicine at
 Children's Medical Center Legacy

Medical Information

Pt. Name: _____
 Address: _____
 _____ City State Zip
 MRN: _____
 DOB: _____
 SSN: XXX-XX-_____
 DOS: _____ SEX: _____

Name: _____ Age: _____ Date: _____

Reason for visit: _____

Referred by: _____

Date of last period: _____ Due Date: _____

Pregnancies: _____ # Children: _____ # Miscarriages: _____ # Ectopics: _____

Year	Gender	Weight	Vaginal or Cesarean	Gest. Age	Complication
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____

Operations	Year	Other Hospitalizations	Year
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Drug allergies: _____

Present medications: _____

	No	Yes
Are your vaccinations up to date (influenza, hepatitis, tetanus, rubella)?	<input type="checkbox"/>	<input type="checkbox"/>
Have you had an ultrasound exam this pregnancy?	<input type="checkbox"/>	<input type="checkbox"/>
Have you had a first or second trimester screening test for Down Syndrome?	<input type="checkbox"/>	<input type="checkbox"/>
Have you had a chorionic villus sampling or an amniocentesis?	<input type="checkbox"/>	<input type="checkbox"/>
Have you had carrier testing for cystic fibrosis?	<input type="checkbox"/>	<input type="checkbox"/>

Emergency Contact Person:

Name: _____ Phone Number: _____



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Have you ever had:

	No	Yes		No	Yes
Anemia	<input type="checkbox"/>	<input type="checkbox"/>	Kidney disease	<input type="checkbox"/>	<input type="checkbox"/>
High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	Urinary infections	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	Transfusions	<input type="checkbox"/>	<input type="checkbox"/>
Heart disease	<input type="checkbox"/>	<input type="checkbox"/>	Herpes Virus	<input type="checkbox"/>	<input type="checkbox"/>
Heart murmur	<input type="checkbox"/>	<input type="checkbox"/>	Infertility/IVF	<input type="checkbox"/>	<input type="checkbox"/>
Autoimmune disease	<input type="checkbox"/>	<input type="checkbox"/>	Surgery on cervix	<input type="checkbox"/>	<input type="checkbox"/>
Tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>	Asthma or lung disease	<input type="checkbox"/>	<input type="checkbox"/>
Sickle Cell disease	<input type="checkbox"/>	<input type="checkbox"/>	Blood clot/DVT	<input type="checkbox"/>	<input type="checkbox"/>
Uterine anomaly	<input type="checkbox"/>	<input type="checkbox"/>	Gall bladder disease	<input type="checkbox"/>	<input type="checkbox"/>
Migraine headaches	<input type="checkbox"/>	<input type="checkbox"/>	Cancer	<input type="checkbox"/>	<input type="checkbox"/>
Hepatitis	<input type="checkbox"/>	<input type="checkbox"/>	HIV	<input type="checkbox"/>	<input type="checkbox"/>
Thyroid disease	<input type="checkbox"/>	<input type="checkbox"/>	Depression	<input type="checkbox"/>	<input type="checkbox"/>
Seizures/epilepsy	<input type="checkbox"/>	<input type="checkbox"/>	Rh(D) sensitized	<input type="checkbox"/>	<input type="checkbox"/>

Family History: Have you or any relative (including father and his family) ever had:

	No	Yes		No	Yes
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	Tay Sachs	<input type="checkbox"/>	<input type="checkbox"/>
Heart disease	<input type="checkbox"/>	<input type="checkbox"/>	Huntington Chorea	<input type="checkbox"/>	<input type="checkbox"/>
Heart attack	<input type="checkbox"/>	<input type="checkbox"/>	Ashkenazi background	<input type="checkbox"/>	<input type="checkbox"/>
Stroke	<input type="checkbox"/>	<input type="checkbox"/>	Canavan disease	<input type="checkbox"/>	<input type="checkbox"/>
High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	Familial Dysautonomia	<input type="checkbox"/>	<input type="checkbox"/>
Cystic Fibrosis	<input type="checkbox"/>	<input type="checkbox"/>	Sickle Cell disease	<input type="checkbox"/>	<input type="checkbox"/>
Recurrent Preg loss	<input type="checkbox"/>	<input type="checkbox"/>	Hemophilia	<input type="checkbox"/>	<input type="checkbox"/>
Thalassemia	<input type="checkbox"/>	<input type="checkbox"/>	Muscular dystrophy	<input type="checkbox"/>	<input type="checkbox"/>
Spina Bifida	<input type="checkbox"/>	<input type="checkbox"/>	Mental retardation	<input type="checkbox"/>	<input type="checkbox"/>
Congenital Heart Defect	<input type="checkbox"/>	<input type="checkbox"/>	Fragile X syndrome	<input type="checkbox"/>	<input type="checkbox"/>
Down Syndrome	<input type="checkbox"/>	<input type="checkbox"/>			

Alcohol use? No Yes Illegal drugs? No Yes
 Tobacco? No Yes _____ Pks/day Years _____

Social History: Type of Work: _____

Any other problem? _____