MFM Patient Medical History

Referring MD: _____ Location: _____

Family History

Mother: ☐Living or ☐Deceased: _____ **Father**: ☐Living or ☐Deceased: _____

Sibling(s)— # of Brothers Living: _____ Deceased: _____ # of Sisters Living: _____ Deceased: _____

☐ Diabetes _____ ☐ Heart Disease _____ ☐ High Cholesterol _____

☐ Stroke _____ ☐ High Blood Pressure _____ ☐ Cancer _____

☐ Other _____

Social History

- Have you ever smoked cigarettes? **YES or NO** Smokeless tobacco (ie. E-cigarettes)? **YES or NO**
  - If YES, **currently**? How many packs per week? _____
- Do you drink alcohol? **YES or NO**
  - If YES **currently**, how many drinks per week? _____
- Have you ever used illicit drugs or drugs not prescribed to you? **YES or NO**
- Have you ever experienced domestic violence? **YES or NO**
- Do you regularly use a seat belt? **YES or NO**
- Do you get regular exercise? **YES or NO**
  - If YES, how many times a week? _____
- Marital status? **Married(Spouse name:_____) Single Widowed Divorced Separated**
- Highest education level achieved: **High School College Graduate Degree Other: _____**
- Current Occupation: _____

Past History (*Medical Problems/Illnesses*):

_____

_____

_____

Allergies/Reactions ☐ none

_____

_____

_____

Medications – Current ☐ none

_____

_____

_____

_____

Surgeries – Procedure/Date/Place

_____

_____

_____

_____

Have you ever had any blood transfusion(s)? Yes or No **If yes, how many? _____**

Genetic Screening/Teratology Counseling – Including patient, baby's father, or anyone in either family with:

	Y	N	Who?		Y	N	Who?
Parents (Mother & Father of Baby) age 35 yrs or older as of est. Date of Delivery				Thalassemia (Italian, Greek, Mediterranean, or Asian background): MCV LESS than 80			
Neural Tube Defect (Meningomyelocele, Spina Bifida, or Anencephaly)				Congenital Heart Defect (CHD)			
Down Syndrome				Tay-Sachs (Ashkenazi Jewish, Cajun, French, Canadian)			
Canavan Disease (Ashkenazi Jewish)				Dysautonomia (Ashkenazi Jewish)			
Sickle Cell Disease or Trait				Hemophilia or other blood disorders			
Muscular Dystrophy				Cystic Fibrosis			
Huntington's Chorea				Mental Retardation/Autism			
Tested for Fragile X				Other inherited Genetic or Chromosomal Disorder			
Maternal metabolic Disorder (Type 1 Diabetes, PKU)				Patient or Baby's Father had a child with birth defects not listed above.			
Recurrent pregnancy loss or stillbirth							

Past Obstetrical/Gynecologic History

First day of Last Menstrual Period: ____/____/____ Flow Type: **Heavy** **Light** **Cramps** **Clots**

Contraception? _____Age of Menopause? _____

History of any sexually transmitted disease(s): **NONE** **YES** (Type): _____

Abnormal pap smear? **YES or NO** If **YES,** any treatment? _____

Received any vaccinations? **Gardasil (HPV)** YES or NO **Chicken Pox** (or infection) YES or NO **Influenza** YES or NO
Any other Vaccinations? _____

# of pregnancies (include current) _____ # of live births _____ # of miscarriages _____ # of abortions _____

Deliveries:	**Date**	**Vaginal/Cesarean**	**Forceps/Vacuum**	**Sex**	**Weight**

Review of Systems (Check all that apply):

Gastrointestinal ☐No problems
☐Poor appetite ☐Constipation
☐Abdominal pain ☐Nausea/vomiting
☐Indigestion ☐Rectal Bleeding
☐Trouble swallowing ☐Diarrhea/Bloody stools
☐Other _____

Cardiovascular ☐No problems
☐Chest pain ☐Hx of angina/heart attack
☐High blood pressure ☐Hx of irregular heart beat
☐Hx of poor circulation ☐Other _____

Pulmonary/Lungs ☐No problems
☐Shortness of breath ☐Persistent cough
☐Coughing up blood ☐Asthma/Wheezing
☐Other _____

Muscle/Joint/Bones ☐No problems
☐Swollen joints ☐Joint pain/stiffness
☐Muscle cramps/spasms ☐Back pain
☐Other _____

Neurologic ☐No problems
☐History of stroke ☐Memory loss
☐Loss of consciousness/blackouts
_____
☐Numbness/Tingling ☐Other _____

Hematologic/Lymphatic ☐No problems
☐Easy bruising ☐Swollen glands
☐Other _____

General ☐No problems
☐Poor sleep ☐Weight gain/loss
☐Fever ☐Headache
☐Other _____

Eyes, Ears, Nose, Throat ☐No problems
☐Blurred vision ☐Hx of glaucoma
☐Loss of hearing ☐Ringing in ears
☐Sinus problems ☐Hoarseness
☐Other _____

Genitourinary ☐No problems
☐Frequent urination ☐Urinary retention
☐Blood in urine ☐Urinary leakage
☐Stool leakage ☐Abnormal periods
☐Painful intercourse ☐Other _____

Skin ☐No problems
☐Itching ☐Easy bruising
☐Change in moles ☐Other _____

Endocrine ☐No problems
☐History of diabetes ☐Excessive thirst
☐Change in tolerance to hot/cold weather
☐Hx of thyroid disease ☐Other

Psychiatric ☐No problems
☐Depression ☐Anxiety
☐Other _____