

Austin Perinatal Associates, P.A.
 David L. Berry, M.D.
 6500 N. Mopac Expwy Bldg 1 Ste 1205
 Austin, TX 78731

PATIENT HISTORY

Date:	Referring Doctor/Midwife:
Name:	Age:
Marital Status:	Partner's Name:

Reason for visit:

Signs and/or symptoms experiencing:

Total # of Pregnancies (Including this one):

Number of living Children:

PREGNANCY HISTORY:		
Month/Year of Pregnancy	Type of Delivery (c/s or vaginal)	Comments (Premature, abnormality, stillbirth, injury or disease while pregnant):

Please Indicate if you have or have had:	Yes	No	If Yes, brief Description:
Breast Disease			
Ovarian Cyst			
Blood Clots			
Infection of uterus, tubes or ovaries			
Tumor of uterus			
Jaundice			
Cancer			
Seizures			
Pneumonia			
Diabetes			
High Cholesterol			
Migraines			
Kidney Disease			
Heart Disease			
Bleeding Tendencies			
High Blood Pressure			
Congenital Heart Disease			
Hepatitis			
Thyroid Disfunctions			
Positive HIV or AIDS test			

SURGERY (Please list what type and year performed):

Date of last PAP: _____ Normal _____ Abnormal _____

Date of last menstrual period: _____ Due Date: _____

Have you ever had a vaginal infection? _____ If yes, please give brief description below:

Have you ever had a Sexually Transmitted Disease (chlamydia, gonorrhea, syphilis, genital warts, herpes, HIV)? _____ If yes, please give brief description below:

Are your periods regular (every 28-30 days)? _____

If no, how many days are in between your periods? _____

Circle one: _____ The flow of your period is Heavy, Light or Moderate?

Please list all medications you are currently taking (include all prescription and over the counter):

Please list all medications you have taken in the past year (include all prescription and over the counter):

PLEASE LIST ALL MEDICATIONS TO WHICH YOU ARE ALLERGIC:

Do you drink alcohol? _____ If yes, how frequently/much? _____

Do you smoke? _____ If yes, how frequently/much? _____

Do you take recreational drugs? _____ If yes, which drugs? _____

How frequently? _____ How recent? _____

Do you have any family history of birth defects? _____ (If yes, please list relationship and description below)

Cystic Fibrosis

Thalassemia

Sickle Cell Anemia

Neural Tube Defect

Heart Defects

Unexplained mental retardation

Chromosomal abnormalities (Down Syndrome, etc.)

Other (please list): _____