Austin Perinatal Associates

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PATIENT HISTORY

Date:	Referring Doctor/Midwife:
Name:	Age: HT: WT: BMI:
Martial Status:	Partner's Name:

Reason for referral (Your or Your Doctor's Concerns):

Signs and/or symptoms experiencing:

Total # of Pregnancies (Including this one):
of term deliveries: Preterm deliveries: Miscarriages/Abortions: Living children:

PREGNANCY HISTORY:		
Month/Year of Delivery	C-section or vaginal delivery/birthweight	Comments (Premature, abnormality, stillbirth, complication, 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			
Lupus			
Hepatitis			
Thyroid Disfunctions			
Positive HIV or AIDS test			

SURGERY (Please list what type and year performed):

Have you ever had a vaginal infection or sexually transmitted disease? _____ Describe:

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

Please list all medications you have taken during this pregnancy (include all prescription or non-Rx):

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 or the father have any family history of birth defects? _____ List relationship and description:
Cystic Fibrosis
Thalassemia
Sickle Cell Anemia
Neural Tube Defect
Heart Defects
Unexplained mental retardation/Neruromuscular
Chromosomal abnormalities (Down Syndrome, etc.)
Any Other History (please list):

REVIEW OF SYSTEMS (check all that apply):

Fever_____	Constipation/diarrhea_____	Depression_____
Body Aches_____	Abdominal pain_____	Difficulty concentrating_____
Headaches_____	Trouble urinating/UTI_____	Hallucinations_____
Dizzy spells_____	Recent vaginal bleeding_____	Too hot/cold_____
Weight change_____	Vaginal discharge_____	Blood sugar issues_____
Visual/Eyes_____	Muscle pain/weakness_____	Swollen lymph nodes_____
Ear/Nose/Throat_____	Bone pain or fractures_____	Anemia_____
Palpitations/chest pain_____	Skin rashes or itching_____	Seasonal Allergies_____
Lung infection/wheezing_____	Numbness/tingling_____	Frequent illnesses_____
Nausea/vomiting_____	Weakness_____	Poor immune system_____