Banner Health®

NEW PATIENT MEDICAL HISTORY
OBSTETRICS

Patient Name: _____ **Date of Birth:** _____

Please provide as much detail as you are able so that we can give you the safest and best care possible.

Primary Care Provider: _____

How did you hear about us? Circle all that apply. Yahoo / Google / Facebook / Health Grades / Pandora /

Other: _____

Do you already have a pediatrician in mind? ❑ **Yes** ❑ **No If so, who?** _____

Preferred Pharmacy (name and location): _____

First day of your last period: _____/_____/_____

Do you have any specific concerns regarding your pregnancy? _____

_____

ALLERGIES

❑ No known allergies

List any allergies and intolerances to **medications, food or the environment.**

Allergy:	**Reaction:**

Are you allergic to: ❑ Latex ❑ Iodine ❑ Seafood ❑ Nickel

MEDICATIONS

❑ Not taking any medications

List any medications you are taking, with dose and how often.

Medication Name:	**Dose:**	**How often?**

List any Vitamins, Supplements and Over the Counter Medicines

1.	**4.**
2.	**5.**
3.	**6.**

VACCINES

List the last date given:

Flu:	Pertussis (Whooping Cough):
Chicken Pox (disease or vaccine):	HPV:

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SURGICAL HISTORY

Have you been hospitalized or had any surgeries? Provide date and reason.

Date:	Reason:	Date:	Reason:

MEDICAL HISTORY

List any current or past medical conditions (please place checkmark by any current problems).

❑ _____

❑ _____

❑ _____

❑ _____

❑ _____

INFECTION HISTORY

Have you or do you currently have any of the following? Please mark all that apply.

	Chickenpox		Hepatitis B or C		Sexually transmitted infection
	Chlamydia		HIV		Syphilis
	Genital Herpes (you or partner)		Human Papilloma Virus (HPV)		Tuberculosis (you or family)
	Gonorrhea		Rash or viral illness since LMP		

Other: _____

OBSTETRIC / PREGNANCY HISTORY

Please list all your pregnancies (live births, miscarriages, ectopics, abortions, etc.) with details below:

Delivery Date/Time	# Weeks at Birth	Result of Pregnancy (vaginal or C-section)	Child's Sex	Weight	Delivery Hospital	Mother/Baby Complications	Neonate Outcome

5100-0009
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ADDITIONAL PREGNANCY HISTORY

Is this a planned pregnancy? ❑ Yes ❑ No
Were you using hormonal contraception within 2 months of last menstrual period? ❑ Yes ❑ No
Were you breastfeeding when you became pregnant? ❑ Yes ❑ No
Did pregnancy result from infertility treatment? ❑ Yes ❑ No If yes, method used: _____

MENSTRUAL HISTORY

Are your periods: ❑ normal amount/duration ❑ abnormal amount/duration
If abnormal, describe: _____
What age did you start menstruating? _____
Are your periods regular (every month)? ❑ Yes ❑ No If no, explain: _____
How long do your periods last: _____
Date of home pregnancy test: ____ / ____ / ____

ETHNIC BACKGROUND

Place a check mark to indicate either you and/or the baby's father:

	Self	Baby's Father	Comments
African			
Asian			
Cajun			
Caucasian			
French Canadian			
Greek			
Italian			
Jewish			
Mediterranean			
Other			

GENETIC HISTORY

Place a check mark to indicate any family members (both **you and baby's father's side of family**) with the following conditions:

	Self	Baby's Father	Other Relative	Comments
Birth Defect				
Canavan Disease				
Congenital Heart Defect				
Cystic Fibrosis				
Down's Syndrome				
Hemophilia				
Huntington's Chorea				
Maternal Metabolic Disorders				
Mental Retardation/Fragile X				
Muscular Dystrophy				
Neural Tube Defect				
Recurrent Pregnancy Loss or Stillbirth				
Sickle Cell Disease				
Tay Sachs				
Thalassemia				
Other:				

5100-0009
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FAMILY HISTORY

List health conditions for each family member.

	Alive	Deceased	Age of Death	Health Condition(s)
Father				
Mother				
Maternal Grandmother				
Maternal Grandfather				
Paternal Grandmother				
Paternal Grandfather				
Brothers				
Sisters				

Will you be 35 or older at the time the baby is born? ❑ Yes ❑ No Will the father be 50 or older when the baby is born? ❑ Yes ❑ No

SOCIAL HISTORY

TOBACCO / ALCOHOL / CAFFEINE / DRUGS

Tobacco/smoking status: Never _____

Current _____ Type _____ Amount _____ Duration _____

Former _____ Type _____ Amount _____ Duration _____

Do you use alcohol? No _____ Yes _____ Type _____ Amount _____ Frequency _____

Do you use Caffeine? No _____ Yes _____ Type _____ Amount _____ Frequency _____

Do you use recreational drugs? No _____ Yes _____ Type _____ Amount _____ Frequency _____

Are you on a special diet? ❑ Yes ❑ No What kind? _____

Do you exercise? ❑ Yes ❑ No Type(s) _____ Hours per Week _____

Your Occupation _____ Do you work with chemicals or radiation (x-rays)? ❑ Yes ❑ No

Do you have cats? ❑ Yes ❑ No Any other pets? ❑ Yes ❑ No What kind? _____

ANESTHESIA / SEDATION HISTORY

Have you ever had general anesthesia? ❑ Yes ❑ No

If yes, did you experience any reaction: _____

Have you ever had sedation for a procedure? ❑ Yes ❑ No

If yes, did you experience any reaction: _____

Have you ever had an epidural/spinal anesthesia? ❑ Yes ❑ No

If yes, did you experience any reaction: _____

5100-0009
(12/2015)

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BLOOD TRANSFUSION HISTORY

Have you ever had a blood transfusion? ❑ Yes ❑ No

If yes, did you experience any reaction: _____

Do you have any objections to a blood transfusion should one be needed? ❑ Yes ❑ No

If yes, explain: _____

DOMESTIC VIOLENCE

Have you ever been physically or emotionally abused by your partner? ❑ Yes ❑ No

Have you been physically hurt by someone within the past year? ❑ Yes ❑ No

If yes, number of times in the past year: _____ By whom: _____

Within the last year, has anyone forced you to have sexual activity? ❑ Yes ❑ No

If yes, number of times in the past year: _____ By whom: _____

5100-0009
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