MIDWEST OB/GYN & MIDWIFERY
HEALTH /MEDICAL HISTORY

Name _____ Today's Date _____
Reviewed by_____

Please fill out this form to the best of your ability. If you are unsure about a particular question, leave it blank. You will have the opportunity to discuss your answers in detail with the midwife.

MEDICAL HISTORY

Do you or anyone in your immediate family (brothers, sisters, parents or grandparents) have any of the following? Please check those that apply.

____ I am adopted

MEDICAL/HEALTH/PROBLEM/CONDITION	Self	Immediate family
High Blood Pressure		
Heart Disease/Heart Attack/Stroke		
Kidney Disease/Bladder Infections		
Epilepsy/Seizures		
Depression/Psychiatric Illness		
Liver Disease/Hepatitis		
Blood Clots/Varicose Veins		
Thyroid Disease		
Asthma/Tuberculosis		
Breast Problems (lumps, cancer, etc.)		
Gynecologic (female problems)		
Infertility		
Operations/Hospitalizations		
Bad or Adverse reaction to anesthesia		
Drug Use (Marijuana, cocaine, crack, etc.)		
IV Drug Use		
Cancer		
Anything Else?		

Do you have any allergies to medications, foods, or latex? Yes ___ No ___
What medications, vitamins, herbal remedies or over-the-counter drugs are you taking now?
_____
Have you ever had a blood transfusion? Yes ___ No ___
Would you accept a blood transfusion if one was needed in an emergency? Yes ___ No ___
Do you feel safe at home? Yes ___ No ___ Do you feel safe at work? Yes ___ No ___
Does anyone ever hit, kick, or strike you, or make you feel scared in any way? Yes ___ No ___

GYNECOLOGIC HISTORY

How old were you when you began having periods? _____
How old were you when you first had intercourse? _____
When was the first day of you last period? _____
Are your periods usually regular? Yes ___ No ___
When was your last pap smear? _____
Have you ever had an abnormal pap smear? Yes ___ No ___
Have you ever had a sexually transmitted disease? Yes ___ No ____
What type of birth control do you use now? _____
What type of birth control have you used in the past? _____

PREGNANCY HISTORY

How many times have you been pregnant? ___ Miscarriages? ___ Abortions? ___
Have any of your children died? Yes ____ No ____
How many living children do you have? _____

Please tell us about your children::

Date Born	Birth Weight	Boy or Girl	Place where born	*Any problems during pregnancy, labor or delivery or postpartum?	Name

* Did you have; high blood pressure, diabetes, preterm labor, unusual bleeding, very long or short labors, trouble pushing, or did the baby have any problems after delivery.