Baptist Health Medical Pavilion
3900 Kresge Way, Suite #30
Louisville, Kentucky 40207
(502)891-8700

You are scheduled for your confirmation of pregnancy visit on

______________________ at ______________________.

Please arrive **20 minutes** prior to your appointment time to allow time to complete appropriate registration forms. You will see a Nurse Practitioner or Physician Assistant at this visit.

Please mail or fax your completed Medical History Form that is attached as soon as possible, and at least one week prior to our scheduled appointment. Completing this Medical History Form and providing it to us prior to your visit will help us to prepare for your visit and will assist with a timely appointment. During this visit we will:

- Confirm your pregnancy with an ultrasound and establish your due date
- Focus on understanding any personal issues that may impact your pregnancy
- Take you to our in-office lab for prenatal blood work
- Provide you with educational materials and community resources to learn about prenatal care

This visit will take approximately two hours. **Due to the nature and length of this visit we ask that you do not bring children with you.**

If you are an existing patient or a new patient and have been seen by another physician for any reason at an office or Emergency Room for this pregnancy please have your medical records faxed one week prior to your scheduled appointment. It is extremely important that we have your records prior to this scheduled appointment. Fax: (502) 891-8752

If you are a new patient please have your previous OB/GYN records faxed one week prior to your scheduled appointment time. Fax: (502) 891-8752.

We appreciate your understanding and cooperation with our requests and look forward to seeing you soon! If you have any further questions about your appointment, contact our Appointments Care Team at (502) 891-8788.

Fax to: (502) 891-8752

MEDICAL HISTORY FORM

Name ______________ Age ______ Address ______________

Home Phone No. ______________ Work Phone No. ______________ Cell Phone No. ______________

Emergency Contact ______________ Relationship ______________ Phone No. ______________

Birthday ______________ Your Occupation ______________

Name of father of baby ______________ Occupation ______________

1. What was the first day of your last menstrual cycle? ______________
2. Since your last period have you experienced any of the following:

☐ Bleeding ☐ Pain ☐ Cramping ☐ Nausea ☐ Vomiting
☐ Headaches ☐ Emotional Problems ☐ Fever ☐ Rashes

I. Medical History

Have you been diagnosed with any of the following:

☐ High blood Pressure ☐ Diabetes Mellitus ☐ Gestational Diabetes ☐ Stroke ☐ Cancer

If yes, when diagnosed? ______________ If cancer, what type? ______________

Nervous System	☐ Migraine Headaches ☐ Epilepsy ☐ Pseudo tumor cerebri ☐ Myasthenia gravis ☐ Multiple Sclerosis ☐ Bell's Palsy ☐ Fibromyalgia ☐ Chronic Fatigue
Thyroid	☐ Graves Disease ☐ Over Active Thyroid ☐ Goiter ☐ Under Active Thyroid ☐ Prior Radiation of Thyroid
Heart Disease	☐ Rheumatic Fever ☐ Mitral Valve Prolapse ☐ Abnormal Heart Valve ☐ Heart Attack/Myocardial Infarction ☐ Abnormal Heart Rhythm ☐ Prior Heart Surgery ☐ Genetic Heart Defect
Lung Disease	☐ Asthma ☐ Pneumonia ☐ Pulmonary Embolus (blood clot) ☐ Bronchitis ☐ Emphysema
Breast	☐ Prior Breast Surgery or Biopsy ☐ Abnormal Mammogram ☐ Breast Cancer
Stomach/Gallbladder	☐ Stomach Ulcer ☐ Gastric Reflux ☐ Gallstones ☐ Anorexia ☐ Bulimia
Liver/Pancreas	☐ Hepatitis A ☐ Hepatitis B ☐ Hepatitis C ☐ Cirrhosis ☐ Pancreatitis ☐ Liver problems
Small and Large Bowel	☐ Irritable Bowel Syndrome ☐ Ulcerative Colitis ☐ Crohn's Disease ☐ Diverticulitis
Urinary Tract	☐ Kidney/Bladder Infection ☐ Kidney Stones ☐ Chronic Renal Failure ☐ Genetic Kidney Disease ☐ Kidney Surgery ☐ Kidney Damage from Diabetes or High Blood Pressure
Mood Disorder	☐ Depression ☐ Bipolar Disorder ☐ Manic Depression ☐ Postpartum Depression ☐ Anxiety/Panic Disorder ☐ Obsessive Compulsive Disorder ☐ Suicide Attempt ☐ Hospitalization for Mental Disorder
Immune Disorder	☐ Lupus ☐ Low Platelet Count ☐ Scleroderma ☐ Antiphospholipid Syndrome ☐ Hereditary Angioedema
Skin	☐ Ehlers-Danlos Syndrome ☐ Hereditary Angioneurotic Edema ☐ Neurofibromatosis ☐ Marfan's Syndrome
Muscular/Joints	☐ Rheumatoid Arthritis ☐ Ankylosing Spondylitis ☐ Gout ☐ Myotonic Dystrophy ☐ Osteoporosis
Phlebitis/Varicose veins	☐ Blood clots in legs or lungs that required hospitalization
Anemia/Blood disorders	☐ Iron Deficiency Anemia ☐ Sickle Cell Anemia or trait ☐ Thalassemia ☐ Von Willebrand's Disease ☐ Hemophilia

1. Have you ever had a blood transfusion(s)? . . . . ☐ Yes ☐ No

   If yes, what year(s) ______________

2. Have you ever had an accident/broken bones? . . . . ☐ Yes ☐ No

   If yes, what year ______________

3. Did you have Chicken Pox as a child? . . . . ☐ Yes ☐ No ☐ Uncertain
   Have you had the Chicken Pox vaccine? . . . . ☐ Yes ☐ No

4. Have you ever had any of the following immunizations:

   ☐ Tetanus - Date________ ☐ T-Dap - Date ________ ☐ Gardasil (HPV) - 1st________ 2nd______ 3rd______

Name______________________________ Date of Birth______________________

II. Gynecology History

1. Age of first menstrual cycle __________ Duration of each cycle __________ Days between cycles__________
2. Have you ever been diagnosed with any of the following:

☐Infertility ☐Abnormal Pap Smear ☐Endometriosis ☐Genital Warts
☐Abnormal Periods ☐Ectopic Pregnancy ☐Two or more miscarriages ☐Gonorrhea
☐Chlamydia ☐HIV ☐HPV ☐Syphilis

3. Do you have a history of genital herpes? . . . . ☐ Yes ☐ No
4. Does your partner have a history of genital herpes? . . . . ☐ Yes ☐ No

III. Obstetrical History (List pregnancies, miscarriages, abortions, ectopic pregnancies)

	Date	Weeks Gest	Labor hrs	Spont. Labor	Induced Labor	Type of Delivery	Live birth	Baby's Wt.	Doctor	Hosp.	Baby's Name	Nursed months	Spinal or epidural	Complications Mom and/or Baby
1														
2														
3														
4														
5														
6														
7														
8														

IV. Medications

1. Name of your current prenatal vitamin: ______________________________
2. List your current medications and their dosage: ______________________________

____
3. List any medications taken in early pregnancy: ______________________________
4. List any herbal medications you are currently taking: ______________________________

V. Surgical History (List the approximate date and type of any surgeries, operations or procedures)

Date	Surgery/Operation	Procedure

VI. Allergies (List any allergies to medications or foods)

____

____

____

Name____ Date of Birth________________________

VII. Social History (Check any items that apply to you)

1. ☐ Tobacco-currently use ☐ Tobacco-used in past. . . . . Date last used______________________
   ☐ Alcohol-currently use ☐ Alcohol-used in past . . . . Date last used______________________
   ☐ Marijuana-currently use ☐ Marijuana-used in past. . . . . Date last used______________________
   ☐ Methamphetamine-currently use ☐ Methamphetamine-used in past. . . Date last used______________________
   ☐ Heroin-currently use ☐ Heroin-used in past . . . . Date last used______________________
   ☐ Cocaine-currently use ☐ Cocaine-used in past . . . . Date last used______________________
2. ☐ Have experienced violence at home or workplace or history of sexual or mental abuse.
3. ☐ Vegetarian ____

VIII. Family History (Referring to the list of medical conditions in Section 1. Medical History, list any chronic illness in your and the father of the baby's immediate family - parents, grandparents, siblings, aunts, uncles, first cousins)

Your side of family

Paternal (Father) Side	Maternal (Mother) Side

Father of baby's side of family

Paternal (Father) Side	Maternal (Mother) Side

Father of baby personal medical history

Name________________________________ Date of Birth________________________

XI. Genetic History

1. Have you ever had an expanded genetic carrier testing panel? . . . . ☐ Yes ☐ No
2. Will you be 35 years or older when this baby is due? . . . . ☐ Yes ☐ No
3. Have you, the baby's father, or anyone in either of your families ever had any of the following disorders? If yes, indicate the relationship of the affected person to you or the baby's father.

   Down Syndrome . . . . ☐ Yes ☐ No Relationship ______________________

   Other Chromosomal abnormality . . . . . ☐ Yes ☐ No Relationship ______________________

   Neural tube defect, i.e. Spina bifida (Meningomyelocele or open spine), Anencephaly . . . . ☐ Yes ☐ No Relationship ______________________

   Hemophilia. . . . . ☐ Yes ☐ No Relationship ______________________

   Muscular Dystrophy . . . . ☐ Yes ☐ No Relationship ______________________

   Cystic Fibrosis. . . . . ☐ Yes ☐ No Relationship ______________________

   Mental Retardation . . . . ☐ Yes ☐ No Relationship ______________________

   Heart Defects Congenital (birth defect) . . . ☐ Yes ☐ No Relationship ______________________

4. Do you or the baby's father have a birth defect? . . . . ☐ Yes ☐ No

   If yes, who has the defect and what is it? ______________________________________

5. In any previous marriages have you or the baby's father had a child born dead or alive or with a birth defect not listed in question #2 above?. ☐ Yes ☐ No

   If yes, who had the defect and what was it? ______________________________________

6. Do you or the baby's father have any close relatives with mental retardation? . . . . ☐ Yes ☐ No

   If yes, indicate the relationship of the affected person to you or to the baby's father:______________________________________

   ☐Male ☐Female Indicate the cause if known: ______________________________________

7. Do you, the baby's father, or a close relative in either of your families have a birth defect, any familial disorder or a chromosomal abnormality not listed above?. . . . . ☐ Yes ☐ No

   If yes, indicate the condition and relationship of the affected person to you or to the baby's father: ______________________________________

8. In any previous marriages, have you or the baby's father had a stillborn child or three or more first trimester spontaneous pregnancy losses? . . . . ☐ Yes ☐ No

   Have either of you had a chromosomal study? . . . . ☐ Yes ☐ No

   If yes, indicate who and the results: ______________________________________

9. If you or the baby's father is of Jewish ancestry, have either of you been screened for Tay-Sachs disease, Canavan's disease, Gaucher's disease of Cystic Fibrosis? . . . . ☐ Yes ☐ No

   If yes, indicate who and the results: ______________________________________

10. If you or the baby's father is African American, have either of you been screened for Sickle Cell trait?. . . . . ☐ Yes ☐ No

    If yes, indicate who and the results: ______________________________________

11. If you or the baby's father is of Italian, Greek, or Mediterranean ancestry, have either of you been tested for B-Thalassemia? . . . . ☐ Yes ☐ No

    If yes, indicate who and the results: ______________________________________

12. If you or the baby's father is of Philippine or Southeast Asian ancestry, have either of you been tested for A-Thalassemia? . . . . ☐ Yes ☐ No

    If yes, indicate who and the results: ______________________________________