Facey Medical Group

An affiliate of PROVIDENCE Health & Services

Ob-Gyn Patient Information & Health History

EMR #: _____

Date: _____

Patient Name: _____

Preferred Name (if any): _____

Primary Phone Number: _____ ☐ Home ☐ Cell

Race (Select one)

☐ American Indian/Alaskan Native ☐ Hispanic/Latin/Spanish Origin
☐ Asian ☐ Native Hawaiian/Pacific Islander
☐ Black/African American ☐ White/Caucasian ☐ Decline to Say

Primary Care Physician (PCP): _____

Date of Birth (mm/dd/yyyy): _____

Relationship Status: ☐ Single ☐ Married/Partnered

Father of Baby: _____

Father's Phone Number: _____

Please list any prescriptions, over the counter medications, supplements and vitamins you are currently taking: _____

Pleas list any known allergies and type of reaction: _____

Emergency Contact Information

THIRD PARTY CONSENT ON FILE? ☐ YES ☐ NO

Emergency Contact Name: _____ Relationship to Patient: _____

Home Phone: _____ Cell Phone: _____ Primary Phone:

Street Address (if different from above): _____

City: _____ State: _____ ZIP: _____ Work Phone (incl. any extension): _____

Health History

	Yes	No		Yes	No		Yes	No
Abnormal Pap	☐	☐	Heart Problems	☐	☐	Mental Health Disorders	☐	☐
Anemia	☐	☐	HIV/AIDS	☐	☐	Postpartum Depression	☐	☐
Anesthetic Complications	☐	☐	Hypertenstion	☐	☐	Blood Type (Rh) Incompatibility	☐	☐
Asthma	☐	☐	Infertility	☐	☐	Seizures	☐	☐
Blood Dyscrasia (disorder)	☐	☐	Kidney Disease	☐	☐	Sickle-Cell Anemia	☐	☐
Breast Problems	☐	☐	Liver Disease	☐	☐	Thyroid Disease	☐	☐
Diabetes (Mellitus or Gestational)	☐	☐	Lupus	☐	☐	Trauma/Violence	☐	☐
Do you authorize the administration of blood products in the event of a medical emergency? *If **no,** please explain:*				☐	☐	Blood Clots (Varicositis/Phlebitis)	☐	☐
Surgeries *If **yes,** list surgeries & dates*	☐	☐						
Hospitalizations *If **yes,** what for?*	☐	☐						

Infection History

Do you:	Yes	No		Yes	No
Live with anyone who has tuberculosis (TB)/have you been exposed to TB?	☐	☐	Have Hepatitis B or C?	☐	☐
Have a history of genital herpes (or your partner)?	☐	☐	Have a history of STI's, including Gonorrhea, Chlamydia,		
Have a rash or viral illness since your last menstrual period?	☐	☐	HPV, Syphilis, or others? (please specify below)	☐	☐

Other conditions not mentioned above: _____

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Family History

Have you or any of your blood relatives had any of the following illnesses? Please include parents, grandparents, siblings or children in either family. Note the family member's age at onset, their relation to you, and whether they are related **maternally (M)** or **paternally (P)** to you.

	Yes	No	Who, Age, M/P		Yes	No	Who, Age, M/P
Anemia	☐	☐		Infertility	☐	☐	
Asthma	☐	☐		Kidney Disease	☐	☐	
Bleeding Problems	☐	☐		Liver Disease	☐	☐	
Cancer	☐	☐		Lupus	☐	☐	
Diabetes	☐	☐		Mental Health Disorders	☐	☐	
Heart Disease	☐	☐		Preeclampsia	☐	☐	
Premature CHD	☐	☐		Pre-term Labor	☐	☐	
Hepatitis	☐	☐		Seizures	☐	☐	
HIV/AIDS	☐	☐		Thyroid Disease	☐	☐	
Hypertension	☐	☐		Other	☐	☐	

Genetic History

Do you, the baby's father, or anyone in **either family** have a history of the following illnesses? Please include parents, grandparents, siblings or children in either family.

	Yes	No	Who, M/P		Yes	No	Who, M/P
Age 35 or older at estimated date of delivery	☐	☐		Cystic Fibrosis	☐	☐	
Thalassemia *(Italian, Greek, Mediterranean, or Asian)*	☐	☐		Huntington's Chorea	☐	☐	
Neural Tube Defect *(Spina Bifida, Meningomyelocele, etc.)*	☐	☐		Autism and/or Mental Retardation **If yes,** was person tested for Fragile X?	☐ ☐	☐ ☐	
Congenital Heart Defect	☐	☐		Other Inherited Genetic or Chromosomal Disorder	☐	☐	
Down Syndrome	☐	☐		Maternal Metabolic Disorder *(EG, Type 1 Diabetes, PKU)*	☐	☐	
Tay-Sachs *(Ashkenazi Jewish, Cajun, French Canadian)*	☐	☐		You or baby's father had a child with birth defects not listed above	☐	☐	
Canavan Disease *(Ashkenazi Jewish)*	☐	☐		Recurrent Pregnancy Loss	☐	☐	
Familial Dysautonomia *(Ashkenazi Jewish)*	☐	☐		Medications/Drugs Taken Since Last Menstrual Period	☐	☐	
Sickle Cell Disease/Trait	☐	☐		Any Other Genetic Conditions Not Listed Here	☐	☐	
Hemophilia (or other blood disorders)	☐	☐					
Muscular Dystrophy	☐	☐					

Social History

Do you drink alcohol? ☐ **No** ☐ **Yes** → Please list how mnay drinks you typically consume in a week:

Glasses of Wine: _____ Beer (12 ounces): _____ Shots: _____ Drinks with .5oz of alcohol: _____

Do you currently use drugs (illegal)? ☐ **No** ☐ **Yes** → Please list: _____

Do you currently smoke tobacco? ☐ **No** → Have you ever regularly smoked tobacco? ☐ **No** ☐ **Yes** → Year you quit smoking: _____

☐ **Yes** → How many packs per day? _____

Do you currently use smokeless tobacco? ☐ **No** ☐ **Yes**

Are you regularly around cats or have cats in your home? ☐ **No** ☐ **Yes**

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Obstetric History

Date of last menstrual period (mm/dd/yyyy): _____

Was this period normal? ☐ Yes ☐ No - Please explain: _____

Total Pregnancies: _____ Full Term (37-40 weeks): _____ Premature (less than37 weeks): _____

Miscarriages: _____ Abortions: _____ Ectopic: _____ Multiples: _____ Living: _____

Pregnancy Details - Please fill out as completely as possible for all pregnancies

	First	Second	Third	Fourth	Fifth
Date of Pregnancy					
Number of Weeks Pregnant					
Vaginal or C-Section?					
Length (in hours) of Labor					
Birth Weight					
Sex & Name of Baby					
Anesthesia Used, if Any					
Preterm Labor					
Currently Living or Deceased?					
Location of Delivery					
Delivering Doctor/CNM					
List Any Complications					

Please return completed form to a member of our reception team. Thank you.