Women First
of Louisville, PLLC
Obstetrics & Gynecology

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) ☐ ☐es 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: _____