



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.

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

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

- Age of first menstrual cycle _____ Duration of each cycle _____ Days between cycles _____
- Have you ever been diagnosed with any of the following:

<input type="checkbox"/> Infertility	<input type="checkbox"/> Abnormal Pap Smear	<input type="checkbox"/> Endometriosis	<input type="checkbox"/> Genital Warts
<input type="checkbox"/> Abnormal Periods	<input type="checkbox"/> Ectopic Pregnancy	<input type="checkbox"/> Two or more miscarriages	<input type="checkbox"/> Gonorrhea
<input type="checkbox"/> Chlamydia	<input type="checkbox"/> HIV	<input type="checkbox"/> HPV	<input type="checkbox"/> Syphilis
- Do you have a history of genital herpes? Yes No
- 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

- Name of your current prenatal vitamin: _____
- List your current medications and their dosage: _____

- List any medications taken in early pregnancy: _____
- 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)

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 or 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: _____