Patient Name: _____
Date of Birth: _____
Account #: _____

Fairhaven Obstetrics & Gynecology, Inc.
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Goshen, IN 46526
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PLEASE FILL OUT ALL PAGES COMPLETELY AND EMAIL OR MAIL BACK AT LEAST 7 DAYS PRIOR TO YOUR APPOITNTMENT. IF YOUR FORM IS NOT RECEIVED 7 DAYS BEFORE YOUR APPOINTMENT, THEN YOU WILL BE RESCHEDULED TO A LATER DATE.

LMP: _____= EDC DATE: _____ **OFFICE USE ONLY**

GESTATIONAL AGE: _____ WT: _____HT: _____ FORM: _____

PRE-PREGNANCY WEIGHT	IF UNKNOWN - HOW MUCH WEIGHT HAVE YOU LOST OR GAINED SINCE BECOMING PREGNANT?

ALLERGIES
(ANY ALLERGIES TO MEDICATIONS OR LATEX?)

ALLERGY	REACTION

MEDICATIONS
(LIST CURRENT MEDICATIONS – INCLUDE ANY VITAMINS OR OVER THE COUNTER MEDICATIONS)

MEDICATION	STRENGTH	FREQUENCY	START DATE

Personal Medical History					
	Y/N	**Date/Treatment**		**Y/N**	**Date/Treatment**
Diabetes			Tuberculosis		
Hypertension			History of Breast Conditions		
Heart Disease			Infertility		
Auto Immune Disorder			Recurrent Pregnancy Loss or Stillbirth		
Kidney Disease/UTI			Gynecological Surgery		
Neurologic/Seizures			Surgeries		
Depression/Anxiety			Thyroid Disorder		
Hepatitis/Liver Disease			Blood Transfusions		
Varicosities			Asthma		

PAST SURGICAL HISTORY List any surgeries you have had (including wisdom teeth removal) and date of procedure		
SURGERY	**DATE**	

TOTAL # PREGNANCIES	FULL TERM 37 WEEKS OR MORE	PREMATURE LESS THAN 37 WKS	MISCARRIAGE	ELECTIVE ABORTION	LIVING CHILDREN

PAST PREGNANCIES (Please start with your oldest child)						
BIRTHDATE	WEEKS AT DELIVERY	HOURS IN LABOR	BIRTH WEIGHT	SEX	C-SECTION OR VAGINAL	ANY COMPLICATIONS EPIDURAL, ANESTHESIA?

MENSTRUAL AND PAP HISTORY			
FIRST DAY OF YOUR LAST PERIOD:		HAVE YOU HAD SPOTTING OR BLEEDING SINCE PREGNANT?	If yes, please describe bleeding and frequency:
AGE PERIODS STARTED:		WHEN WAS YOUR LAST PAP SMEAR TEST?	WHEN: WHERE:
HOW OFTEN ARE YOUR PERIODS?		DO YOU HAVE HISTORY OF AN ABNORMAL PAP SMEAR?	
LENGTH OF MENSTRUAL FLOW:		WHEN? WHERE? WAS YOUR ABNORMAL PAP TREATED?	
LAST FORM OF CONTRACEPTION:		ANY NAUSEA/VOMITING?	
WHEN DID YOU STOP CONTRACEPTION?		OTHER MENSTRUAL AND PAP HISTORY NOT LISTED	
DID YOU DO A HOME PREGNANCY TEST?	WHEN?	HAVE YOU HAD AN ULTRASOUND FOR THIS PREGNANCY?	WHEN? DUE DATE? WHERE?
HAVE YOU RECEIVED THE FLU VACCINE?	WHEN?	DO YOU PLAN TO BREAST OR BOTTLE FEED?	

FAMILY MEDICAL HISTORY			
Condition	**Y/N**	**Age of Onset**	**Persons Relationship to you**
Heart Attack			
High Blood Pressure			
High Cholesterol			
Stroke			
Diabetes			
Thyroid Disorder			
Asthma/Lung Disorder			
Anxiety/Depression			
Mental Disorder			
Lupus			
Breast/Uterine/Ovarian Cancer			
Other Cancers			
Other Family History Not Listed			

DAILY LIVING					
	Y/N	HOW MUCH		Y/N	NOTES
DO YOU DRINK ALCOHOL? CURRENT/FORMER			DO YOU SMOKE CIGARETTES? FORMER SMOKER?		
DO YOU DRINK COFFEE, TEA OR COLA?		SPECIFY	ANY CHEMICAL EXPOSURE?		
DO YOU USE ANY ILLICIT/RECREATIONAL DRUGS?		WHAT KIND?	HAVE YOU HAD ANY X-RAYS DURING THIS PREGNANCY?		
HAVE YOU USED ANY DRUGS IN THE PAST? WHAT KIND?			DO YOU EXERCISE?		
WHO LIVES IN YOUR HOUSE WITH YOU? ANY PETS?			CURRENT OR HISTORY OF EMOTIONAL/PHYSICAL ABUSE?		

INFECTION HISTORY					
	Y/N	PLEASE SPECIFY		Y/N	PLEASE SPECIFY
ANY HISTORY OF TB OR EXPOSURE TO TB?			HAVE YOU HAD CHICKEN POX OR THE VACCINE?		WHICH?
ANY HISTORY OF INFECTIOUS DISEASES? (MONO HEPATITIS, MENNINGITIS, HIV)			ANY RASH, FEVER, OR VIRAL ILLNESS SINCE YOUR LAST PERIOD?		
ANY HISTORY OF STD, GONORRHEA, CHLAMYDIA, HPV, SYPHILLIS?			DO YOU HAVE A CAT?		INDOOR OR OUTDOOR
DO YOU OR YOUR PARTNER HAVE ANY HISTORY OF GENITAL HERPES?			ANY HISTORY OF BLOOD TRANSFUSION?		
OTHER INFECTION HISTORY NOT LISTED?			ANY TATTOOS?		HOW MANY?
HAVE YOU TRAVELED OUTSIDE OF THE US IN THE PAST 3 MONTHS?		WHERE?			

NAME	AGE	Race	RELIGION	OCCUPATION
PATIENT EDUCATION LEVEL:				
FATHER OF BABY				
MARITAL STATUS HOW LONG?	Married Engaged Separated Single and in a relationship Single not in a relationship			

GENETIC SCREENING (Includes patient, baby's father or anyone in **either** family)					
	Y/N	Specify which family member.		Y/N	Specify which family member.
CANAVAN'S DISEASE			MUSCULAR DYSTROPHY		
CONGENITAL HEART DEFECT			NEURAL TUBE DEFECTS (ANENCEPHALY, MENINGOMYELOCELE, SPINA BIFIDA)		
CYSTIC FIBROSIS			ANY BIRTH DEFECTS		
DOWN'S SYNDROME			ANY INHERITED GENETIC/ CHROMOSMAL DISORDER		
HEMOPHILIA/BLOOD DISORDERS			SICKLE CELL DISEASE OR TRAIT		
HUNTINGTON'S CHOREA			TAY-SACHS (JEWISH, FRENCH, CANADIAN)		
MATERNAL METABOLIC DISORDER (DM/PKU)			THALASSEMIA		
MENTAL RETARDATION/AUTISM					