HUNTSVILLE OB/GYN ASSOCIATED, P.A.
J.E. SPEED, D.O. S.G. TYGART, M.D.

DATE: _____ ID# _____

NAME:_____
Last First M.I.

PREFERRED PHARMACY_____ DRUG ALLERGIES _____

LOCATION: _____

MENSTRUAL HISTORY

LAST MENSTRUAL PERIOD_____(DEFINITE) APPROXIMATE ____/____/_____ __UNKNOWN

MENSES MONTHLY? __YES __NO FREQUENCY ____(DAYS) MENSES BEGAN (AGE ONSET) _____

PRIOR MENSES ____/____/____ (DATE) WERE YOU ON BIRTH CONTROL AT CONCEPTION? ___Y ___N

POSITIVE PREGNANCY TEST (DATE) _____/_____/_____

PAST PREGNANCIES (LAST SIX)

	DATE, MONTH/YEAR	WEEKS GESTATION AT DELIVERY	HOURS OF LABOR	BIRTH WEIGHT	VAG OR C SECTION	ANESTHESIA TYPE	PLACE OF DELIVERY
1							
2							
3							
4							
5							
6							

WERE ANY OF YOUR DELIVERIES PRE-TERM? ___Y ___N DELIVERY/ COMPLICATIONS: _____

PAST MEDICAL HISTORY (PLEASE PUT Y OR N)

DIABETES __
HYPERTENSION__
HEART DISEASE __
AUTOIMMUNE DISORDER __
KIDNEY DISEASE / UTI __
NEUROLOGIC / EPILEPSY __
PSYCHIATRIC __
HEPATITIS / LIVER DISEASE __
VARICOSITIES / PHLEBITIS __
THYROID DYSFUNCTION __
TRAUMA / DOMESTIC VIOLENCE__

HX OF BLOOD TRANS __
RH SENSITIZED __
PULMONARY (TB, ASTHMA) __
DRUG ALLERGIES __
BREAST __
HX OF ABN PAP __
UTERINE ANOMALY / DES __
ANESTHESIA COMPLICATIONS __
GYN SURGERY (S) _____
SURGERIES (YEAR AND REASON) _____
_____

INFERTILITY __
RELEVANT FAMILY HISTORY
_____
OTHER _____

GENETIC SCREENING/TERATOLOGY COUNSELING
INCLUDES PATIENT, BABY'S FATHER, OR ANYONE IN EITHER FAMILY WITH:
(PLEASE CIRCLE YES OR NO)

PATIENT AGE GREATER THAN 35 Y N

THALASSEMIA (ITALIAN, GREEK, MEDITERRANEAN, OR ASIAN BACKGROUND): MCV < 80 Y N

NEURAL TUBE DEFECT (MENINGOMYELOCELE, SPINA BIFIDA, OR ANENCEPHALY) Y N

CONGENITAL HEART DEFECT Y N

DOWN SYNDROME Y N

TAY-SACHS (EG, JEWISH, CAJUN, FRENCH CANADIAN) Y N

SICKLE CELL DISEASE OR TRAIT (AFRICAN) Y N

HEMOPHILIA Y N

MUSCULAR DYSTROPHY Y N

CYSTIC FIBROSIS Y N

HUNTINGTON CHOREA Y N

MENTAL RETARDATION / AUTISM Y N (IF YES, WAS PERSON TESTED FOR FRAGILE X ?) Y N

OTHER INHERITED GENETIC OR CHROMOSOMAL DISORDER Y N

MATERNAL METABOLIC DISORDER (EG, INSULIN DEPENDENT DIABETES, PKU) Y N

PATIENT OR BABY'S FATHER HAD A CHILD WITH BIRTH DEFECTS NOT LISTED ABOVE Y N

RECURRENT PREGNANCY LOSS, OR A STILLBIRTH Y N

MEDICATIONS/STREET DRUGS/ALCHOHOL SINCE LAST MENSTRUAL PERIOD Y N

IF YES, AGENTS _____

ANY OTHER Y N

INFECTION HISTORY
(PLEASE CIRCLE Y OR N)

HIGH RISK HEPATITIS B/ IMMUNIZED Y N

LIVE WITH SOMEONE WITH TB OR EXPOSED TO TB Y N

PATIENT OR PARTNER HAS HISTORY OF GENITAL HERPES Y N

RASH OR VIRAL ILLNESS SINCE LAST MENSTRUAL PERIOD Y N

HISTORY OF STD, GC, CHLAMYDIA, HPV, SYPHILIS Y N

OTHER _____