East Cooper OB/GYN

Women Devoted to Women

New Obstetric Patients

Name: ____ **Date:** _____________

Preferred Name (Nickname): _____________________________ Date **of birth**________________________

Occupation: ____ **Age**: ______________

Father of the baby:__________________________________**Occupation:**______________________________

Your Pap Will Be Sent To Gen Path

It is your responsibility to inform your nurse of the lab preferred by your insurance company.
Please circle the correct lab below for any indicated bloodwork:

LabCorp   East Cooper   MUSC   Quest

Date of last menstrual period: ___________________
Were your periods regular?   Yes   No
Is this pregnancy the result of fertility medication or treatment?   Yes   No

Please list any <u>ALLERGIES</u>:

____

List any <u>medications</u> you are currently taking:

Name of medication	Dose	Times per day

Preferred pharmacy and location:____

Please circle any of the following symptoms you are experiencing:
fatigue   nausea   vomiting   cramping   breast tenderness   vaginal bleeding

Have you ever been told you have had MRSA (methicillin resistant staph aureus) infection?
Yes / No   When____________________

Medical and Surgical History:

Please list any **medical problems** for which you take medications or see a doctor regularly:

____

Date of last pap smear______________________Location_________________________________

Have you ever had an **abnormal pap smear**: *No* *Yes?*

If "yes" when: _______________ What treatment was required: ______________________________

Please circle any of the following diseases you have had or for which you have been treated:

Gonorrhea *Chlamydia* *Syphilis* *Herpes* *Trichomonas* *Venereal Warts*

Please list any **surgeries** you have had:

Operation	Year	Complications
______________________________	________	______________________________
______________________________	________	______________________________

Family History:

Please list any relatives with the following medical problems:

(please list which family members)

Breast cancer ________________________

Ovarian cancer ______________________

Uterine cancer _______________________

Colon cancer ________________________

Other cancers _______________________

Diabetes ____________________________

High blood pressure___________________

Lung disease__________________________

Kidney problems______________________

Blood disorders_______________________

Twins _______________________________

Thyroid disease_______________________

Heart disease_________________________

Stroke ______________________________

Blood clots __________________________

Other (please list)_____________________

Genetic History:

Please list any relatives in your family or the father of the baby's family with the following conditions:

____ Thalassemia

____ Spina bifida (neural tube defect)

____ Down Syndrome

____ Mental retardation

____ Sickle cell disease / trait

____ Hemophilia

____ Heart defect at birth

____ Muscular dystrophy

____ Cystic fibrosis

____ Huntington chorea

____ Other inherited genetic disorder

____ >3 miscarriages or a stillbirth

As your ancestry may determine certain genetic conditions you are at risk for, please mark if you are:

____ Ashkenazi Jewish **____ Mediterranean** **____ African American**

____ French Canadian **____ Asian** **____ Cajun**

Social History:

Marital Status *single* *stable relationship (not married)* *married* *separated* *divorced*

Do you smoke cigarettes? *No* *Yes* How many each day? _____ How many years? _____
Do you drink alcohol? *No* *Yes* How many drinks per week? ____________________
Do you use recreational drugs? *No* *Yes*
Are you exposed to unusual chemicals or radiation at work? *No* *Yes*
Do you have any pets? (please circle) *Cats* *Dogs* *Birds* *Other:* _____________________

Have you ever had chickenpox? *Yes* *No*

Obstetrical History

Please list each pregnancy and outcome:

	Year	Full / Preterm	Type of Delivery Abortion / Miscarriage Vaginal / C-section	Gender	Birth Weight	Complications
1st	_____	Full / Pre	A / M / V / C	M / F	_____lbs ____oz	_______________
2nd	_____	Full / Pre	A / M / V / C	M / F	_____lbs ____oz	_______________
3rd	_____	Full / Pre	A / M / V / C	M / F	_____lbs ____oz	_______________

Pregnancy Planning

Are you planning to breastfeed or formula feed your baby? ________________________________

Are you considering an epidural for pain management during labor? Yes___ No ___ Unsure ____

Any specific concerns or issues you wish to address:

____

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Thank you for entrusting your care to East Cooper OBGYN