Welcome to Rose Midwifery! Please fill out the following questions to the best of your knowledge!

Date:__________________________

Name: _______________________________ Preferred pronouns: (circle) She He They Other____

Date of Birth: ________________ Age: _______

What is the main reason for your visit today?

Annual Exam Missed period/confirm pregnancy New OB visit Return OB visit Birth Control

Other:_______________________________________

Who is your primary care provider? ________________________________

Were you referred by another healthcare provider or clinic? Yes / No If so, who?_________________

How did you hear about us? ________________________________

Medications: Please list all medications you take, including over-the-counter medications and vitamins. Please include the dose if known.

______________________________________ ______________________________________

______________________________________ ______________________________________

______________________________________ ______________________________________

Allergies: Are you allergic to any medications? Yes / No

If yes, please list them and the reaction to each one below:

______________________________________ ______________________________________

______________________________________ ______________________________________

What pharmacy do you use?

Pharmacy Name_________________________ Pharmacy phone #_______________________

Pharmacy address (or cross streets) ____

Medical History

Have **you** ever been diagnosed with any of the following medical problems?

- Diabetes Yes / No
- High Blood Pressure Yes / No
- Heart Disease Yes / No
- High Cholesterol Yes / No
- Autoimmune Disease Yes / No
- Kidney Disease Yes / No
- Frequent Bladder Infections Yes / No
- Neurologic Disorder Yes / No
- Seizure Disorder Yes / No
- Migraines Yes / No
- Mental Health Condition Yes / No
- Depression Yes / No
- HIV Yes / No
- When was your last flu shot? _______
- Hepatitis Yes / No
- Varicose Veins Yes / No
- Thyroid Disorder Yes / No
- History of Blood Clots Yes / No
- Received a blood transfusion Yes / No
- Rh negative Yes / No
- Asthma Yes / No
- Tuberculosis Yes / No
- Cancer Yes / No
- Sickle Cell disease or trait Yes / No
- Anemia Yes / No
- Bleeding Disorder Yes / No
- Involved in a major accident Yes / No
- Other_________________________

Menstrual History

- At what age did you start your period?_____
- What was the first day of your last period? _________
- How often do your periods come? Every___________days/weeks
- How many days do your periods last? ____________
- Are your periods regular or irregular? (circle one)
- Is your menstrual flow light, moderate, or heavy? (circle one)
- Do you have pain with your periods? Yes / No

PAP history

When was your last PAP smear? ______________________

Have you ever had an abnormal PAP smear? Yes / No If yes, when and where? _____________

Did you receive any treatment for an abnormal PAP? Yes / No If yes, what?________________

Have you received the Gardasil immunization to prevent cervical cancer? (circle one)

None One Shot Two Shot All 3 Shots

Sexual History

Are you currently sexually active? Yes / No   If yes, with: Men   Women   Both

What are you currently using for birth control? ________________________________

What birth control have you used in the past? (circle any that apply)

None   Natural Family Planning   Withdrawal/Pull Out   Male Condoms

Female Condoms   Diaphragm   Progesterone Only pills   Birth Control Pills

NuvaRing   OrthoEvra Patch   Depo-Provera Injection (3 month)

Mirena IUD (5 year)   Paraguard (copper/10 year) IUD   Skyla (3 year) IUD

Nexplanon Implant   Implanon Implant

Have you ever been diagnosed with any of the following?

- Gonorrhea   Yes / No
- Chlamydia   Yes / No
- Genital Herpes (HSV)   Yes / No
- Genital Warts   Yes / No
- Syphilis   Yes / No
- Pelvic Inflammatory DiseaseYes / No

Reproductive History

Have you ever been evaluated or treated for infertility? Yes / No

Have you ever been diagnosed with or treated for the following?

Ovarian Cysts: Yes / No   Fibroids: Yes / No   Endometriosis: Yes / No

Pregnancy History

How many times have you been pregnant? ________

How many children born full term (37+ weeks)? ________

How many children born pre-term (at or less than 36weeks 6 days)? _________

How many miscarriages? ________

How many abortions/terminations? ________

How many living children do you have? _______

Tell us about your past pregnancies:

Date of	Weeks at Delivery	Baby's weight	Boy or Girl?	Type of delivery (vaginal, forceps, cesarean?)	Place of Delivery	Any complications?

Surgical History

Have you ever had surgery before? Yes / No   If yes, please list below:

__________________________________   __________________________________

__________________________________   __________________________________

Have you ever been hospitalized overnight? Yes / No   If yes, please list below:

___________________________________   ___________________________________

___________________________________   ___________________________________

Social History

Are you: Single   Married   Divorced   Partnered   Other   Widowed

Do you currently smoke? Yes / No   If yes, how much? _________________

Have you ever smoked? Yes / No   If yes, when did you quit? _______   How much did you smoke?_____

Do you drink alcohol?   Yes / No   If yes, how many drinks per week? ______

Do you use marijuana? Yes / No   If yes, what type? _________   How many times per week? ________

Do you use any other drugs? Yes / No   If yes, what type? ________   How often? _________

Have you ever been physically or sexually abused?   Yes / No   Are you safe at home?   Yes / No

Do you regularly exercise?   Yes / No   Do you eat a healthy/balanced diet?   Yes / No

Family History

What is your race/ethnic background? _______________ Are you of Ashkenazi Jewish descent? Yes / No

Does anyone in your close family have any of the following conditions? Please indicate if maternal or paternal side and their relationship to you. **Include only siblings, parents, and grandparents.**

History of:	Yes/ Who?	No
Diabetes		
Heart Disease		
Heart Attack		
High Blood Pressure		
Kidney Disease/UTI		
Hepatitis/ Liver Disease		
TB/asthma		
Neurologic/ epilepsy		
Migraine		
Autoimmune Disorder		
Stroke/ blood clots		
Sickle cell disease/trait		
Thalassemia		
Anemia		
Thyroid Disorder		
Depression/Psychiatric		
Trauma/Violence		
Hemophilia		

History of:	Yes/Who?	No
High Cholesterol		
Down Syndrome		
Heart defects		
Neural Tube Defects		
Muscular Dystrophy		
Mental Retardation		
Cystic Fibrosis		
Osteoporosis		
Cleft lip or palate		
Infertility/ DES exposure		
Deafness/ Blindness		
Breast Cancer		
Ovarian Cancer		
Uterine Cancer		
Colon Cancer		
Other Cancer		
Other		

Review of Current Symptoms

Do you **currently** have any of the following?

- Rash/skin lesions Yes / No
- Vision changes Yes / No
- Double Vision Yes / No
- Hearing Problems Yes / No
- Sore throat Yes / No
- Tooth/mouth pain Yes / No
- Difficulty breathing Yes / No
- Shortness of Breath Yes / No
- Chronic Cough Yes / No
- Chest Pain/Pressure Yes / No
- Palpitations Yes / No
- Abdominal Pain Yes / No
- Nausea/Vomiting Yes / No
- Frequent diarrhea Yes / No
- Frequent constipation Yes / No
- Blood in stool Yes / No
- Painful urination Yes / No
- Blood in urine Yes / No
- Muscle/joint pain Yes / No
- Headaches Yes / No
- Dizziness/weakness Yes / No
- Depression/Anxiety Yes / No
- Bleeding/ Bruising Yes / No
- Hair loss Yes / No
- Heat/cold intolerance Yes / No

Is there anything other information not covered above you would like us to know to guide us in providing the best care? Please comment on any other medical/personal/family history here: _______

____

____

We look forward to partnering with you in your health care and pregnancy!