Essex County
OB/GYN ASSOCIATES, INC
Caring for Generations

Obstetrics Patient Information

Welcome to our practice - we are glad you are here!

Appointment Date: _____ **Appointment with** (Doctor or Midwife)**:** _____

Name: _____ **Date of Birth:** _____

If you have ever been pregnant? Yes ◯ No ◯ **If yes, how many times?** _____

Number of Vaginal Deliveries: _____

Number of C-Sections: _____

Number of Miscarriages: _____

Number of Terminations: _____

Is this a planned pregnancy? Yes ◯ No ◯

Date of last Menstrual Period? _____ **Period Intervals:** _____

What is Your Occupation? _____

What is Your Educational Level? _____

Your Social Support: _____

Do you have a history of? (Please check any that you think may apply)

◯ Emotional Abuse ◯ Sexual Abuse ◯ Physical Abuse

Name of Father of the baby? _____ **What is his Age?** _____

What is his Occupation? _____ **What is his Education?** _____

What is his Relationship to you? _____ **Is the Father Involved?** _____

Do you Smoke? Yes ◯ No ◯ If yes, how many cigarettes per day? _____

Do you consume Alcohol? Yes ◯ No ◯ If yes, how many drinks? Per day _____ Per week _____

Have you consumed any alcohol since your last menstrual period? Yes ◯ No ◯

If yes, how much and when? Amount: _____ Date(s): _____

Pharmacy Name/Location: _____

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Have you seen our website? **EssexCountyOBGYN.com**

Name: _____ **Date of Birth:** _____

Do you currently or have you <u>ever</u> used any Street Drugs? Yes ◯ No ◯

Do you consume Caffeine? Yes ◯ No ◯ If yes, how many cups per day? _____

Do you Exercise? Yes ◯ No ◯ If yes, how many times per week? _____

Current Medications: _____

Please list any Allergies you have: (Medications and Foods) _____

PREGANANCY HISTORY

Total Number of Pregnancies: _____ Number Delivered at Full Term: _____ Number Delivered Prematurely: _____

Number of Induced Miscarriages: _____ Number of Spontaneous Misccarriages: _____ Number Ectopic Pregnancies: _____

Number of Multiple Births: _____ Number of Children Living: _____

Will you be older than 35 at the time of your delivery? Yes ◯ No ◯

Do you, the father of the baby (FOB), or any family member have any of the following conditions? (Please circle answer)

Thalassemia	☐ You	☐ FOB	☐ Other	Huntington's Chorea	☐ You	☐ FOB	☐ Other
Neural Tube Defect	☐ You	☐ FOB	☐ Other	Mental Retardation	☐ You	☐ FOB	☐ Other
Down's Syndrome	☐ You	☐ FOB	☐ Other	Fragile X	☐ You	☐ FOB	☐ Other
Tay Sachs Disease	☐ You	☐ FOB	☐ Other	Other Genetic Diseases	☐ You	☐ FOB	☐ Other
Sickle Cell Anemia	☐ You	☐ FOB	☐ Other	Child with birth defects	☐ You	☐ FOB	☐ Other
Hemophilia	☐ You	☐ FOB	☐ Other	>3 Miscarriages	☐ You	☐ FOB	☐ Other
Muscular Dystrophy	☐ You	☐ FOB	☐ Other	Cystic Fibrosis	☐ You	☐ FOB	☐ Other
Stillbirths	☐ You	☐ FOB	☐ Other				

Have you used any medications since your last menstrual period? Yes ◯ No ◯

If yes, what medications: _____

Please continue to page 3

Name: _____ **Date of Birth:** _____

Other Genetic History

Cat Exposure Yes ◯ No ◯ Toxic Exposure Yes ◯ No ◯

Varicella Immune Yes ◯ No ◯ TB risk factors Yes ◯ No ◯

What is your Ethnicity? _____ **What is the baby's Father's Ethnicity?** _____

Have you ever had any of the following Gynecological Surgeries? (Please check all that apply)

__ Abdominal Hysterectomy __ Vaginal Hysterectomy __ Caesarean Section __ Laparoscopy

__ Tubal Ligation __ Pelviscopy __ Ovarian Cystectomy __ Hysteroscopy

__ LEEP __ D & C

__ Removal of Ovaries: Right ◯ Left ◯ Both ◯

__ Other: _____

Have you ever had any of the following? (Please check all that apply)

__ Abnormal Pap Smears __ HPV __ Chlamydia __ Herpes

__ Hepatitis __ HIV __ Endometriosis

__ Pelvic Inflammatory Disease __ Infertility __ Recurrent Miscarriage

__ Fibroid Uterus __ Recurrent Ovarian Cyst __ Chronic Pelvic Pain

__ Polycystic Ovarian Syndrome __ Polycystic Ovarian Failure __ Received HPV Vaccine

__ Diabetes __ High Blood Pressure (Hypertension) __ Heart Disease

__ Autoimmune Disease __ Kidney Disease __ Pulmonary Disease (Asthma) __ Breast Disease

__ Thyroid Disease __ Hyperthyroidism __ Hypothyroidism __ Psychiatric Illness

__ Hepatitis __ Varicosities __ Blood Transfusions

__ Other: _____

Have you ever had any of the following other surgeries? (Please check all that apply)

__ Appendectomy __ Breast Augmentation __ Breast Biopsy __ Breast Lumpectomy

__ Breast Mastectomy __ Breast Reduction __ Cholecystectomy (Removal of Gall Bladder)

__ Other Abdominal: _____

__ Hernia __ Orthopedic:

__ Cardiac: _____ Other: _____

Are any of the following diseases in your family? If yes, then who? (Please check all that apply)

__ Breast Cancer: _____ __ Ovarian Cancer: _____

__ Uterine Cancer: _____ __ Colon Cancer: _____

__ Heart Disease: _____ __ Diabetes: _____

__ Stroke: _____ __ Hypertension: _____

__ Mental Health or Behavioral Health Issues: _____ __ Other: _____

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Thank you.