Women's Health Center of Northfield Hospital
2000 North Avenue
Northfield, MN 55057-1697

Patient Information Sticker

Date: ____________________

PERSONAL MEDICAL AND OBSTETRICAL HISTORY

Allergies

____

____

Medications

Please list all of the medications you are taking, including any vitamins, herbal medicines, and "over-the-counter" medications.

NAME OF MEDICATION	DOSE	FREQUENCY

Please provide the following information regarding your past OB history , including the number of pregnancies, the date (month/year), type of delivery (C-section or vaginal), etc., for each pregnancy. Finish on the back of this sheet, if you need more space.

Total # of Pregnancies	Full Term	Premature	Abortions	Miscarriages	Ectopics	Twins, etc.	# Living

Date	Weeks of Gestation	Length of Labor	Birth Weight	Sex M / F	Type of Delivery	Anesthesia	Place of Delivery	Pre-Term Labor	Name of Child

Date	Complications / Comments

Date of last menstrual period?______________________ Date of last Pap Smear? ______________________

Any abnormal Pap Smears? ❑ YES ❑ NO ____

Have you ever had a sexually transmitted infection or pelvic inflammatory disease? ❑ YES ❑ NO

If yes which one(s)? ____

Please check if you now have or have ever had any of the following:

❑ Cancer	❑ Thyroid Problems	❑ Epilepsy	❑ Migraine Headaches
❑ Heart Disease	❑ Lupus or Arthritis	❑ High Blood Pressure	❑ Bowel / G.I. Problems
❑ Kidney Disease	❑ Anorexia / Bulimia	❑ Diabetes	❑ Depression / Mental Illness
❑ Hepatitis	❑ Asthma	❑ Blood Clots	❑ Anemia_______________
❑ Bleeding Problems	❑ Herpes	❑ HIV / AIDS	❑ Sexually Transmitted Infections
❑ Frequent Urinary Tract Infections		❑ None	

Surgical History

Have you ever had Surgery? ❑ YES ❑ NO

If yes, please list date and operation ______________________________

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Social History

Are you? ❑ Married ❑ Single ❑ Divorced ❑ Separated ❑ Widowed ❑ Significant Other

Occupation ______________________________

Religious / Cultural needs?............................❑ YES ❑ NO

Chemical / Radiation Exposure? ....❑ YES ❑ NO

Pre - Pregnancy tobacco use? ....❑ YES ❑ NO

Pre - Pregnancy cigarettes per day?.............❑ YES ❑ NO Less than I Pack per Day____ ❑ More than 1 Pack / Day ❑ Other ___

Pre - Pregnancy alcohol use? ....❑ YES ❑ NO Pre - Pregnancy alcohol drinks per day? ____________________

Current tobacco use? ....❑ YES ❑ NO

Current cigarettes per day?...........................❑ Less than I Pack / Day ....❑ More than 1 Pack / Day ____________ ❑ Other

Current alcohol use? ....❑ YES ❑ NO Current alcohol drink per day? ____________________

Recreational drug use? ....❑ YES ❑ NO

Restricted diet?..❑ YES ❑ NO

Family and Genetic History

Unknown?...❑ YES ❑ NO Is the patient adopted?.....................................❑ YES ❑ NO

Have you or has the baby's father had a child born with a birth defect? ....❑ YES ❑ NO

If yes, please describe______________________________

Did you or your baby's father have a birth defect?...❑ YES ❑ NO

If yes, please describe: ______________________________

Have you or the baby's father had any genetic testing?...❑ YES ❑ NO

Do you or does the baby's father have a history of multiple pregnancy losses (miscarriages or stillborns)? ....❑ YES ❑ NO

If yes, please describe: ______________________________

Has anyone in your family or the baby's father's family had a child with any abnormality such as mental retardation, birth defects, or inherited disease like Cystic Fibrosis, Muscular Dystrophy, or Hemophilia? ....❑ YES ❑ NO

If yes please describe ______________________________

Are you or is the baby's father of Eastern European (Ashkenazi) Jewish Ancestry? ....❑ YES ❑ NO

If yes have you had Tay-Sachs screening? ....❑ YES ❑ NO Have you had Canavan screening? ....❑ YES ❑ NO

Are you or is the baby's father African or African American? ....❑ YES ❑ NO

If yes have you had Sickle Cell screening?..❑ YES ❑ NO

Are you or is the baby's father Caucasian?...❑ YES ❑ NO

If yes have you had Cystic Fibrosis screening? ....❑ YES ❑ NO

Are you or is the baby's father of Mediterranean or Southeast Asian Ancestry?..❑ YES ❑ NO

If yes, have you had Thalassemia (Inherited Anemias) screening? ....❑ YES ❑ NO

Will you be 35 years old or older at the time of delivery?...❑ YES ❑ NO

Psychosocial Screening

Do you have a history of depression, or are you currently depressed?...❑ YES ❑ NO

Do you feel safe where you live?...❑ YES ❑ NO

Are you currently being physically, emotionally, or sexually mistreated?...❑ YES ❑ NO

Have you ever been physically, emotionally, or sexually mistreated?..❑ YES ❑ NO

Are there any problems (job, transportation, etc.) that may make it hard for you to make it to your appointments? ....❑ YES ❑ NO