Facey Medical Group

With Providence

Ob-Gyn Patient Information & Health History

EMR #: _____

Date: _____

Patient Name: _____

Preferred Name (if any): _____

Primary Phone Number: _____ ☐ Home ☐ Cell

Primary Care Physician (PCP): _____

Date of Birth (mm/dd/yyyy): ____/____/_____

Relationship Status: ☐ Single ☐ Married/Partnered

Race (Select one)

☐ American Indian/Alaskan Native
☐ Asian
☐ Black/African American
☐ Hispanic/Latin/Spanish Origin
☐ Native Hawaiian/Pacific Islander
☐ White/Caucasian
☐ Decline to Say

Father of Baby: _____

Father's Phone Number: _____

Please list any prescriptions, over the counter medications, supplements and vitamins you are currently taking: _____

Pleas list any known allergies and type of reaction: _____

THIRD PARTY CONSENT ON FILE? ☐ YES ☐ NO

Emergency Contact Information

Emergency Contact Name: _____ Relationship to Patient: _____

Home Phone: _____ Cell Phone: _____ Primary Phone:

Street Address (if different from above): _____

City: _____ State: _____ ZIP: _____ Work Phone (incl. any extension): _____

Health History

	Yes	No		Yes	No		Yes	No
Abnormal Pap			Heart Problems			Mental Health Disorders		
Anemia			HIV/AIDS			Postpartum Depression		
Anesthetic Complications			Hypertenstion			Blood Type (Rh) Incompatibility		
Asthma			Infertility			Seizures		
Blood Dyscrasia (disorder)			Kidney Disease			Sickle-Cell Anemia		
Breast Problems			Liver Disease			Thyroid Disease		
Diabetes (Mellitus or Gestational)			Lupus			Trauma/Violence		
Do you authorize the administration of blood products in the event of a medical emergency? If no, please explain:						Blood Clots (Varicositis/Phlebitis)		
Surgeries If yes, list surgeries & dates								
Hospitalizations If yes, what for?								

Infection History

Do you:	Yes	No		Yes	No
Live with anyone who has tuberculosis (TB)/have you been exposed to TB?			Have Hepatitis B or C?		
Have a history of genital herpes (or your partner)?			Have a history of STI's, including Gonorrhea, Chlamydia,		
Have a rash or viral illness since your last menstrual period?			HPV, Syphilis, or others? (please specify below)		

Other conditions not mentioned above: _____

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Family History

Have you or any of your blood relatives had any of the following illnesses? Please include parents, grandparents, siblings or children in either family. Note the family member's age at onset, their relation to you, and whether they are related **maternally (M)** or **paternally (P)** to you.

	Yes	No	Who, Age, M/P		Yes	No	Who, Age, M/P
Anemia				Infertility			
Asthma				Kidney Disease			
Bleeding Problems				Liver Disease			
Cancer				Lupus			
Diabetes				Mental Health Disorders			
Heart Disease				Preeclampsia			
Premature CHD				Pre-term Labor			
Hepatitis				Seizures			
HIV/AIDS				Thyroid Disease			
Hypertension				Other			

Genetic History

Do you, the baby's father, or anyone in either family have a history of the following illnesses? Please include parents, grandparents, siblings or children in either family.

	Yes	No	Who, M/P		Yes	No	Who, M/P
Age 35 or older at estimated date of delivery				Cystic Fibrosis			
Thalassemia (Italian, Greek, Mediterranean, or Asian)				Huntington's Chorea			
Neural Tube Defect (Spina Bifida, Meningomyelocele, etc.)				Autism and/or Mental Retardation If yes, was person tested for Fragile X?			
Congenital Heart Defect				Other Inherited Genetic or Chromosomal Disorder			
Down Syndrome				Maternal Metabolic Disorder (EG, Type 1 Diabetes, PKU)			
Tay-Sachs (Ashkenazi Jewish, Cajun, French Canadian)				You or baby's father had a child with birth defects not listed above			
Canavan Disease (Ashkenazi Jewish)				Recurrent Pregnancy Loss			
Familial Dysautonomia (Ashkenazi Jewish)				Medications/Drugs Taken Since Last Menstrual Period			
Sickle Cell Disease/Trait				Any Other Genetic Conditions Not Listed Here			
Hemophilia (or other blood disorders)							
Muscular Dystrophy							

Social History

Do you drink alcohol? ☐ No ☐ Yes ➔ Please list how many drinks you typically consume in a week:

Glasses of Wine: _____ Beer (12 ounces): _____ Shots: _____ Drinks with .5oz of alcohol: _____

Do you currently use drugs (illegal)? ☐ No ☐ Yes ➔ Please list: _____

Do you currently smoke tobacco? ☐ No ➔ Have you ever regularly smoked tobacco? ☐ No ☐ Yes ➔ Year you quit smoking: _____

☐ Yes ➔ How many packs per day? _____

Do you currently use smokeless tobacco? ☐ No ☐ Yes

Are you regularly around cats or have cats in your home? ☐ No ☐ Yes

CONTINUED ON THE NEXT PAGE

Obstetric History

Date of last menstrual period (mm/dd/yyyy): ____/____/_____

Was this period normal? ☐ Yes ☐ No - Please explain: _____

Total Pregnancies: _____ Full Term (37-40 weeks): _____ Premature (less than37 weeks): _____

Miscarriages: _____ Abortions: _____ Ectopic: _____ Multiples: _____ Living: _____

Pregnancy Details - Please fill out as completely as possible for all pregnancies

	First	Second	Third	Fourth	Fifth
Date of Pregnancy					
Number of Weeks Pregnant					
Vaginal or C-Section?					
Length (in hours) of Labor					
Birth Weight					
Sex & Name of Baby					
Anesthesia Used, if Any					
Preterm Labor					
Currently Living or Deceased?					
Location of Delivery					
Delivering Doctor/CNM					
List Any Complications					

Please return completed form to a member of our reception team. Thank you.

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