VANDERBILT UNIVERSITY
MEDICAL CENTER

Patient Label or Patient Identifiers

Center for Women's Health
Obstetrics Patient History

Patient Completed Information

Patient Name____

Personal Information

Home phone: ______________________________________ Cell phone: ______________________________________

Your significant other_______________________________ ☐ Husband ☐ Domestic Partner

Father of baby (if different than significant other): ____

Your occupation ______________________________________ Father's occupation ____________________________

Emergency contact person ______________________________ Relationship to you ____________________________

Emergency contact phone ______________________________

Health Information

What was the first day of your last menstrual period? ____

Are you allergic to latex? .... ☐ Yes ☐ No

Are you allergic to any medicines? .... ☐ Yes ☐ No

If yes, what medicines? ____

What medicines are you currently taking (include name and dose)? ____

____

____

Do you have any spiritual or cultural needs that would affect how we care for you? .... ☐ Yes ☐ No

If yes, please describe ____

Do you have any objections to being given blood products? .... ☐ Yes ☐ No

Do you smoke cigarettes? .... ☐ Yes ☐ No

Do either of your parents have a problem with alcohol or drug use? .... ☐ Yes ☐ No

Does your partner have a problem with alcohol or drug use? .... ☐ Yes ☐ No

In the past, have you had problems in your life because of alcohol or other drugs,
including prescription medicines? .... ☐ Yes ☐ No

In the past month have you drunk any alcohol or used any drugs? .... ☐ Yes ☐ No

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Information about Your Past Pregnancies

Pregnancy number	1	2	3	4	5
Birthdate					
Boy or Girl					
Baby's birth weight					
Vaginal birth, cesarean section, miscarriage, or abortion					
Pain management during labor					
Feeding: breast or bottle					
Child's name					
Weeks at time of delivery					
Hours in labor					
Did you have any problems with this pregnancy such as gestational diabetes, phenylketonuria (PKU), high blood pressure, preterm labor, difficult birth, or unusual bleeding during delivery?					

Please ask for another page 2 of this document to list more pregnancies.

Medical History

	You		Your Immediate Family (if **yes**, write relationship of family member)		
Have had twins, triplets, or other multiples	Yes	No	Yes	No	Don't know
Infertility	Yes	No	Yes	No	Don't know
More than one miscarriage or stillbirth	Yes	No	Yes	No	Don't know
Cancer	Yes	No	Yes	No	Don't know
High blood pressure	Yes	No	Yes	No	Don't know
Heart disease	Yes	No	Yes	No	Don't know
Diabetes, thyroid, or other endocrine disease	Yes	No	Yes	No	Don't know
Varicose veins or blood clots	Yes	No	Yes	No	Don't know
Depression or other mental health problems	Yes	No	Yes	No	Don't know
Lupus or other autoimmune disease	Yes	No	Yes	No	Don't know
HIV	Yes	No	Yes	No	Don't know
Other: ______________________	Yes	No	Yes	No	Don't know

Have you had any surgeries?	Yes	No	If **yes**, please list:
Have you ever been hospitalized other than for childbirth?	Yes	No	If **yes**, for what reasons:

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Medical History *(continued)*

Have you had chicken pox or the chicken pox vaccine?	Yes	No
Do you work around children or babies?	Yes	No
Do you have asthma or any other lung disease?	Yes	No
Do you have seizures or a neurological disease?	Yes	No
Do you have anemia or other blood disease?	Yes	No
Do you have Crohn's, colitis, or other digestive disease?	Yes	No
Have you ever had any breast disease?	Yes	No
Do you have urinary tract problems or frequent urinary tract infections?	Yes	No
Have you had human papillomavirus (HPV), herpes, or other sexually transmitted disease?	Yes	No
Gynecological problems:		
Abnormal pap smears	Yes	No
Fibroids	Yes	No
Incompetent cervix	Yes	No
Other: ____________________	Yes	No
Do you have a history of sexual or physical abuse?	Yes	No

Your and Your Family's Genetic History

Have you had a baby at age 34 or older? .... ☐ Yes ☐ No

	You		Your Immediate Family, including Baby's Father (if **yes**, write relationship of family member)		
Neural tube defect	Yes	No	Yes	No	Don't know
Congenital heart defect	Yes	No	Yes	No	Don't know
Tay-Sachs, Canavan, or Gaucher disease	Yes	No	Yes	No	Don't know
Ashkenazi Jew, Cajun, or French Canadian descent	Yes	No	Yes	No	Don't know
Sickle cell disease	Yes	No	Yes	No	Don't know
African or Caribbean descent	Yes	No	Yes	No	Don't know
Thalassemia (MCV less than 80)	Yes	No	Yes	No	Don't know
Hemophilia or other blood disorders	Yes	No	Yes	No	Don't know
Muscular dystrophy	Yes	No	Yes	No	Don't know
Cystic fibrosis	Yes	No	Yes	No	Don't know
Huntington's disease	Yes	No	Yes	No	Don't know
Intellectual disability or autism	Yes	No	Yes	No	Don't know
Down syndrome	Yes	No	Yes	No	Don't know
Fragile X	Yes	No	Yes	No	Don't know
Other inherited or chromosomal disorder	Yes	No	Yes	No	Don't know
Other structural birth defect not listed above: ____________________	Yes	No	Yes	No	Don't know

Patient/Legal Representative Print name: ____________________

Patient/Legal Representative Signature: ____________________

Relation: ____________________ Date: __________ Time: __________