Perinatal Associates of NEW MEXICO

Medical History Questionnaire

Patient Name: «PatientFirstLastName» DOB: «PatientDOB» PANM #: «PatientNumber»

Social History	Yes	No
Do you crave any non-food items?		
Have you traveled outside of the country in the last year? If yes, where?		
Have you consumed any alcohol during this pregnancy?		
Do you have a history of or are you currently using drugs?		
Do you smoke tobacco? If yes, how many per day?		
List any medication or Latex allergies.		
List any medications/vitamins/supplements you have taken since becoming pregnant, including dosages.		
Preferred Pharmacy (Include address):		

OB History		
When was the first day of your last menstrual period (LMP)?		
Are you certain about your LMP?	**YES**	**NO**
Including your current pregnancy and losses, how many times have you been pregnant?		

List your pregnancies below including any complications.

Date	Gender	Type of Delivery (Vaginal or C-Section)	Baby's Weight	Weeks At Del.	Pregnancy/Delivery Complications

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GYN History	Yes	No	Partner
Do you or your partner have a history of HIV?			
Do you or your partner have a history of Genital Herpes?			
Do you have a history of Sexually Transmitted Disease?			
When was your last pap smear? Was it normal?			
Have you ever had an abnormal pap smear?			
When was your last flu vaccine?			
When was your last TDAP (Tetanus, Diphtheria and Pertussis) vaccine?			
Have you ever had chicken pox or received the vaccine?			

Medical History	Yes	No	Comments (Include Dates and Current Doctor)
Anemia			
Asthma			
Autoimmune Disease			
Blood Clotting Disease			
Depression/Psychiatric Disorder			
Diabetes			
Gastrointestinal Disease			
Heart Disease			
Hypertension			
Infertility			
Liver Disease			
Neurologic Disorder/Seizures			
Renal Disease			
Thyroid Dysfunction			
Uterine Abnormalities			
Other history not listed above			

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Surgical History	
List any surgeries or hospitalizations below. Please include the date.	Date

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1.		
2.		
3.		
4.		
5.		
Have you had your wisdom teeth removed?	YES	NO
Have you ever had a LEEP procedure or Cone biopsy?	**YES**	**NO**

Family History

	Living	**Age**	**Medical Problems/Cause of death**
Mother	Yes No		
Father	Yes No		

Family History – Genetic Diseases	**Yes**	**No**	**Family Member**
Birth Defects			
Blood Clotting Disease			
Congenital Heart Defect			
Cystic Fibrosis			
Down Syndrome			
Genetic Diseases			
Hematologic Disorders – Sickle Cell, Hemophilia			
Intellectual Disability – Autism, Mental Retardation			
Neural Tube Defect – Spina Bifida			
Neuromuscular Disease – Muscular Dystrophy			

Patient Signature: _____ Date: _____