HENDERSON AND WALTON WOMEN'S CENTER, P.C.
PATIENT HISTORY

Physician: *Office Location:*

NAME ______________________________ **AGE** __________

Please take a few minutes to complete this questionnaire, and plan to bring it with you for your scheduled **OB** appointment. ***If you have been receiving OB care at another facility, you will need to bring your prenatal records with you during this visit.**

1) Is this your first pregnancy? If not, how many times have you been pregnant? # miscarriages # preterm births # full term births ______
2) If this is not your first pregnancy, please list any complications with previous pregnancies: ______________________________
3) For this pregnancy, have you had a positive pregnancy test in a medical facility? Will you bring the results with you? __________
4) Please list the first day of your last menstrual cycle?
5) Prior to pregnancy, would you say you had a menstrual cycle once a month? ______
6) Were you using anything for birth control when you became pregnant? ________ If so, please explain or list:
7) Please help us with your medical history by answering the following questions:
   - A. Please list any illnesses that you have been diagnosed with: ______________
   - B. Have you ever been diagnosed with hepatitis? _______
   - C. Have you ever had chicken pox?
   - D. Have you ever been treated for a sexually transmitted disease? _______ If so, please list:
   - E. Have you had x-rays or exposure to radiation or chemicals during this pregnancy? Please list:
   - F. Have you ever had a blood transfusion? When? ______________
   - G. Please list previous surgeries and dates: ______________________
   - H. Were you taking any medications/drugs, prior to finding out that you were pregnant? Please list: ______________________
   - I. Please list any medications you are taking now: ______________________
   - J. Are you allergic to any medications? Please list: ______________
   - K. Do you smoke? How much per day?
   - L. Do you drink alcohol? How much?
   - M. Do you wear seatbelts? Do you own any cats? _______
8) Please list all of your immediate family members (ex. mother, father, siblings, grandparents) that have been diagnosed with the following:

Heart disease or stroke	High blood pressure ______________
Stroke	Cancer ______________
Diabetes	Kidney disease/stones ______________
Seizure disorders	Tuberculosis ______________
Thyroid problems	Other ______________

SIGNED ______________________________ **DATE** ______________

Click "Send" to email form to Henderson & Walton Women's Center