EST. 1965

LEE OBSTETRICS & GYNECOLOGY

General Information:

☐ Check here if already an established patient at Lee Obstetrics and Gynecology
(If so, please list any change in your personal information below)

Name: _____

Address: _____

_____

Emergency Contact Person: _____

Relation: _____

Contact Number: _____

Phone Numbers: Home: _____

Mobile: _____

Work: _____

Place of Employment: _____

Type of Work: _____

Any heavy lifting or strenuous activity associated with your position? ☐ Yes ☐ No (if "yes" describe below)

_____

_____

Medical History:

Have you ever had Chicken Pox (or had the vaccine)? ☐ Yes ☐ No
Do you have or have you been diagnosed with any of the following medical problems?

☐ Hypertension	☐ Diabetes	☐ Asthma	☐ Chest Pain
☐ Stroke	☐ Blood Clots	☐ Kidney Disorders	☐ Lupus
☐ Anemia	☐ Sickle Cell	☐ Heart Condition	☐ Chronic Pain
☐ Back Pain	☐ Edema		

If you checked any above or have any other chronic (longstanding) medical problems, please describe in detail on next page:

Medical Problem	Date diagnosed?	Managing Physician?
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

(List any additional on back of this sheet)

Medications:

Do you currently take any prescription or non-prescription medication (including herbal supplements)?
☐ Yes ☐ No (if "yes" describe below)

Medication	Dose	Prescribing Physician?
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Have you ever taken any prescription or non-prescription medication (including herbal supplements) for more than 2 weeks?
☐ Yes ☐ No (if "yes" describe below)

Medication	Dose	Prescribing Physician?
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Allergies

Are you allergic to Latex? ☐ Yes ☐ No

Medication	Year Diagnosed	Reaction to Medication
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Surgical History

Have you ever had any type of surgery? ☐ Yes ☐ No (if "yes" describe below)

Type of Surgery	Date performed	Surgeon (add location if not local MD)
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Obstetrical History

Please list all pregnancies below; please include any miscarriages or abortions

Date	Vaginal/C-Section	Male/Female	Weight	Delivering Physician and Location
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

(please list any additional deliveries on back) Circle if more listed on Back

Did you use fertility medication during this pregnancy? ☐ Yes ☐ No
Were you under the care of a Reproductive Specialist? ☐ Yes ☐ No

Pregnancy Complications or Significant Events

During Pregnancy: Please check if occurred during any of your pregnancies)

- ☐ High blood pressure
- ☐ Break your water before 37 weeks
- ☐ Regular contractions before 37 weeks
- ☐ Need for cerclage placement
- ☐ Referral to high risk OB/GYN (UAB)
- ☐ Genetic or structural issues with the baby
- ☐ Excessive vomiting requiring hospitalization
- ☐ Fetal Death
- ☐ Delivery before 37 weeks
- ☐ Bleeding after 20 weeks
- ☐ Diabetes (diet or medication controlled)
- ☐ Growth problems with the baby
- ☐ Need for more than 2 ultrasounds
- ☐ Problems with the placenta
- ☐ Admission to hospital during pregnancy
- ☐ Infections or severe illnesses

Please describe in more detail on the next page if you checked any of the above, and describe any additional pregnancy issues during you pregnancies that you may have had:

Pregnancy complications:

_____
_____
_____
_____
_____
_____
_____

During Delivery: (Please check if occurred during the delivery of your baby)

- ☐ Forceps or vacuum delivery
- ☐ Anesthesia complications
- ☐ Problems with delivering baby's shoulders
- ☐ Need for blood transfusion
- ☐ Need for antibiotics
- ☐ Placental abruption
- ☐ Large vaginal tear (3rd or 4th degree)
- ☐ Fetal macrosomia (baby larger than 9 lbs)
- ☐ Large amount of bleeding during delivery
- ☐ Abnormal or worrisome fetal heart tracing
- ☐ Seizure
- ☐ Need for Magnesium infusion

Please describe in more detail below if you checked any of the above, and describe any additional issues during your delivery that you may have had:

_____
_____
_____
_____
_____
_____
_____

After Delivery: (Please check if occurred after the delivery of your baby)

- ☐ Large amount of bleeding
- ☐ Depression
- ☐ Infection
- ☐ Need for blood transfusion
- ☐ Blood Clots
- ☐ High blood pressure
- ☐ Seizure
- ☐ Heart issues
- ☐ Need for readmission to hospital

Please describe in more detail below if you checked any of the above, and describe any additional issues during your delivery that you may have had:

_____
_____
_____
_____
_____
_____
_____

Gynecologic History

When was your last Pap Smear: _____ (date)
Do you have a history of any abnormal pap smears? ☐ Yes ☐ No
Have you ever had any of the following procedures performed on you cervix?

☐ Colposcopy _____ (date)
☐ LEEP _____ (date)
☐ Cold Knife Conization _____ (date)

Do you have a history of any sexually transmitted diseases?

☐ Herpes Virus (1 or 2) ☐ Chlamydia ☐ Gonorrhea ☐ Syphilis
☐ HIV

Social History

☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Engaged

Do you currently **use tobacco** in any form? ☐ Yes ☐ No
If yes, how much per day _____
Have you recently quit using tobacco? ☐ Yes ☐ No
If yes, how long has it been since you quit _____
Do you currently **drink alcohol** in any form? ☐ Yes ☐ No
If yes, how much per day _____
Do you currently **use any drugs** in any form? ☐ Yes ☐ No
If yes, how much per day _____

Family History

Does yours or your husband's (partner's) family have a history of any of the following or other genetic abnormalities or birth defects?

☐ Mental Retardation
☐ Down's Syndrome
☐ Duchenne Muscular Dystrophy
☐ Cardiac (Heart) Defects
☐ Neurofibromatosis
☐ Polycystic Kidney Disease
☐ Turner Syndrome
☐ Cystic Fibrosis
☐ Canavan Disease
☐ Haemophilia
☐ Neural Tube Defects
☐ Phenyketonuria
☐ Tay-Sachs Disease

Please describe in more detail below if you checked any of the above, and describe any additional genetic abnormalities or birth defects in your family:

_____
_____
_____

Additional Information:

Please list below any additional information that you think we need to know that would help us take care of you during your pregnancy:

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____