Oakwood Women's Centre at Seton Williamson — **Patient History (OB)**

Date _____Name _____ Birth Date _____ Age _____ Race/Ethnicity _____

Phone: Home_____ Work_____ Cell _____ Email _____

Preferred Pharmacy: Name _____Address _____Zip Code_____ Phone _____

Is there someone we can thank for referring you? _____ Primary Physician _____

Circle your OWC at Seton Williamson Physician: Thai Teng Chao

Although some of the information requested below may not seem pertinent, it helps us provide you with the best care. We ask that you fill out ALL of the following questions completely.

REASON FOR YOUR VISIT (details if necessary) :_____

Date of last **Annual Exam**_____ Date of Last **Pap Smear** _____
Have Paps ever been Abnormal? _____ When & did you receive any treatment_____
Have you ever had a **Mammogram**?_____ Any Abnormalities?_____
Have you ever had a **Blood Transfusion**? (List date/reason) _____
Would you **accept blood or blood products** in case of an emergency? _____ If not, please explain_____
Have you ever had **Chicken Pox**? _____
Have you ever had complications with **Anesthesia** of any kind? Please explain_____
Did your mother receive a drug called DES when she was pregnant with you? _____

REPRODUCTIVE HISTORY

How far apart are your menstrual cycles (ex.28-30days) _____ How many days do you have bleeding (i.e. 5-7 days) _____

When was the FIRST day of your **last period**? _____ How **certain** are you: □ Very □ Somewhat □ Not at all

DATE you got your **first POSITIVE pregnancy test**? _____ Was the test done at: □ Home □ Clinic □ an MD office

Were you **desiring pregnancy**? □ YES □ NO □ UNSURE_____

Were you using any form of birth control at the time you got pregnant?_____ (If YES, what type: _____)

Total # of pregnancies _____ Total # of live children _____ # of Abortions (list dates)_____
Miscarriages or Ectopics (list dates & how far along you were): _____

Date of Delivery	# Weeks Pregnant	Hours in Labor	Birth Weight	Sex & Name	Delivery Type	Anesthesia Type	Location	Complications (i.e. preterm labor)

SURGICAL HX

Please list any surgeries or hospitalizations you have undergone (D&C, Hysterectomy, Cesarean Section)
Year of Surgery Type / Reason for MD Hospital

_____

_____

_____

Meds & ALL

List **Drug Allergies** (and the Reaction you had):

_____
_____
_____
_____
_____
_____

List **all medications** (include over-the-counter and supplements), **Doses**, the **Reason** you are taking, and **Who prescribes** it:

_____
_____
_____
_____
_____

PATIENT PAST MEDICAL HX & FAMILY HX

PERSONAL & FAMILY HISTORY (please place an "X" in the *WHITE* boxes that apply)

	You	Mother	Father	Maternal Grandma	Maternal Grandpa	Paternal Grandma	Paternal Grandpa	Brothers or sisters	Children	OTHER family members
Anemia										
Ashkenazi Jewish descent (Eastern European or Russian)										
Arthritis										
Asthma										
Birth defects (i.e. cleft palate, spina bifida…..)										
Clotting disorder, or deep vein thrombosis										
Blood disorders (ex. ITP, sickle cell…)										
Breast disorders										
Cancer, Breast										
Cancer, Colon										
Cancer, Ovarian										
Cancer, Uterine										
Colon polyps										
Diabetes										
Endometriosis										
Epilepsy										
Gallbladder disease										
Genetic disorders (i.e. mental retardation, cystic fibrosis…)										
Glaucoma										
Heart disease or MVP										
High cholesterol										
High blood pressure										
Kidney Disease/stones										
Mental Illness, type?										
Menstrual irregularities										
Osteoporosis										
Pelvic Inflammatory dis.										
Stroke										
Thyroid disease										
Uterine anomalies										
…Still Living?	**X**									
…Deceased at Age?	**----**									

OTHER DISEASES/ILLNESSES:

SOCIAL HISTORY

Marital Status (please check one):

_____Single/Not Dating
_____Singe/ Dating
_____In a committed relationship
_____Engaged
_____Married
_____Divorced
_____Widowed

PARTNER'S NAME: _____ **Age:**_____

Safety: Do you feel safe in your current relationship: Yes No
If not please explain_____

Have you ever been physically abused in a relationship: Yes No
If so, please explain _____

Have you ever had an unwanted sexual encounter: Yes No
If so, please let us know when this occurred: _____
_____

Substance Use: Do you drink alcohol: Yes No
How many drinks per day or week: _____
Do you currently use any illicit drugs: Yes No
Type _____
How often _____
Do you smoke cigarettes: Yes No Never Current Former
How many per day _____
How long have you been a smoker: _____

Occupation: _____

Do you Exercise: Yes No
Type _____
How often _____

Infection Risk:
Are you currently sexually active? Yes No
Sexual preference (circle one): Heterosexual Lesbian Bisexual
How many sexual partners in the last 1 year? _____
In your lifetime: 1-5__ 5-10__ 10-20__ 20+___

Have you ever had a sexually transmitted disease (STD)?: Yes No
Hepatitis (Type?) _____
Syphillis (when? treated?) _____
Chlamydia (when? treated?) _____
Gonorrhea (when? treated?) _____
Genital Herpes (taking meds?) _____
HPV (human papilloma virus) _____
Genital warts? _____
HIV _____
OTHER _____

Have you ever had MRSA (Methicillin-resistant Staphylococcus aureus)?
Yes No

PRINT NAME HERE: _____

11/5/2013

REVIEW OF SYMPTOMS

Constitutional:	**Circle One**:		
Frequent Fatigue	Current	Past	N/A
Excess weight gain	Current	Past	N/A
Excess weight loss	Current	Past	N/A
Eyes, Ears, Nose, Mouth:	**Circle One:**		
Frequent or severe headaches	Current	Past	N/A
Frequent lightheadedness	Current	Past	N/A
Breasts:	**Circle One**:		
Lumps	Current	Past	N/A
Pain	Current	Past	N/A
Swelling	Current	Past	N/A
Nipple discharge	Current	Past	N/A
Cardiovascular:	**Circle One:**		
Chest pain	Current	Past	N/A
Fainting	Current	Past	N/A
Swollen/Painful varicose veins	Current	Past	N/A
Calf pain	Current	Past	N/A
Respiratory:	**Circle One**:		
Frequent shortness of breath	Current	Past	N/A
Frequent Hoarseness	Current	Past	N/A
Gastrointestinal:	**Circle One**:		
Nausea/ Vomiting	Current	Past	N/A
Frequent Diarrhea	Current	Past	N/A
Frequent Constipation	Current	Past	N/A
Frequent Heartburn/ reflux	Current	Past	N/A
Abdominal Pain	Current	Past	N/A
Blood in stool	Current	Past	N/A
Hemorrhoids	Current	Past	N/A
Genitourinary:	**Circle One:**		
Urgency	Current	Past	N/A
Frequency	Current	Past	N/A
Pain with urination	Current	Past	N/A
Blood in urine	Current	Past	N/A
Frequent Urine leakage	Current	Past	N/A
Pain with intercourse	Current	Past	N/A
Genital sores	Current	Past	N/A

Genitourinary (continued)	**Circle One:**		
Irregular periods	Current	Past	N/A
Painful periods	Current	Past	N/A
Heavy periods	Current	Past	N/A
No periods	Current	Past	N/A
Possible pregnancy?	Current	Past	N/A
Abnormal vaginal discharge	Current	Past	N/A
Significant PMS	Current	Past	N/A
Integument (skin):	**Circle One:**		
New skin lesions	Current	Past	N/A
Changes to moles/skin lesions	Current	Past	N/A
Musculoskeletal:	**Circle One:**		
Joint pain	Current	Past	N/A
Joint swelling	Current	Past	N/A
Recent back pain	Current	Past	N/A
Endocrine:	**Circle One**:		
Excess bodily hair growth	Current	Past	N/A
Excess hair loss	Current	Past	N/A
Cold intolerance	Current	Past	N/A
Heat intolerance	Current	Past	N/A
Acne	Current	Past	N/A
Thyroid abnormalities/ treatment?	Current	Past	N/A
Psychiatric:	**Circle One:**		
Frequent Anxiety	Current	Past	N/A
Frequent Depression	Current	Past	N/A
Suicidal thoughts	Current	Past	N/A
Psychiatric treatment	Current	Past	N/A
Hematologic/Lymphatic:	**Circle One:**		
Easy bleeding	Current	Past	N/A
Easy bruising	Current	Past	N/A

List any other symptoms bothering you today: _____

_____

_____

YOUR HEIGHT: _____ **YOUR WEIGHT**: _____

PRINT NAME HERE: _____

PATIENT SIGNATURE: _____ **DATE COMPLETED:** _____

Oakwood Women's Centre-Seton Williamson

Genetic Screening Questionnaire

NAME: _____

Will you be 35 years old or older at your due date?	Y	N
Are you or your baby's father of…		
• Jewish background?	Y	N
• Black/African background?	Y	N
• Mediterranean background?	Y	N
• Asian background?	Y	N
• French-Canadian background?	Y	N
Have you…		
• Taken any medications (prescribed or OTC) during this pregnancy?	Y	N
• Had any alcohol (beer, wine, hard liquor) during this pregnancy?	Y	N
• Used any illegal/street drugs (cocaine, marijuana) during this pregnancy?	Y	N
• Taken Accutane, blood thinners, or lithium since your last period?	Y	N
• Had radiation therapy or chemotherapy since your last period?	Y	N
• Take mega dose vitamins, especially vitamin A since your last period?	Y	N
Do you or your baby's father have epilepsy?	Y	N
• And take medication? If yes type _____	Y	N
Do you have diabetes or have you had diabetes with pregnancy and are/were you…	Y	N
• On insulin	Y	N
• On oral hypoglycemic medications	Y	N
• Controlled by diet	Y	N
Are you and the father of your baby first cousins or closer?	Y	N
Have you had…		
• Three or more miscarriages?	Y	N
• A stillborn infant?	Y	N
• A child that died within the first year of life?	Y	N

Have you, the father of your baby, or anyone in either family ever had a child	**Self**	**Father**	**Family**
• With Down Syndrome or other chromosomal abnormality?	Y N	Y N	Y N
• With mental retardation?	Y N	Y N	Y N
• With an open spine (spina bifida), skull defect, or anencephaly?	Y N	Y N	Y N
• With a heart defect?	Y N	Y N	Y N
• With a muscle or neuromuscular disease (muscular dystrophy)?	Y N	Y N	Y N
• With Cystic Fibrosis?	Y N	Y N	Y N
• With Hemophilia, sickle cell, thalassemia, or other blood disorders?	Y N	Y N	Y N
• With any birth defect or genetic disease not listed above?	Y N	Y N	Y N

Patient signature_____date_____