JAMII BIRTH & Wellness Services

2117 Smith Ave, Suite F * Chesapeake, VA 23320
P: 833-JAMII4U (526-4448) F: (757) 859-0007

New Patient Medical History Form

Last Name:_____ **First Name:**_____

Primary Care Physician**:**_____
Pharmacy of choice (please include address)**:**_____
_____
What was the first day of your last menstrual period(LMP)?_____
At the time of conception were you using any contraceptives? If so, What type._____

Medication History:

Please list all medications that you may have taken in the last 6 months. This will include any over the counter medications, prescription medications, vitamins, and supplements. Please use the back of the form if you have more medications than the space below provides.

Name of Medication	Dose/Frequency of medication	Currently or past medication?

Allergies:

Please list any allergies as well as reactions.

Allergy	Reaction

Past Medical/Surgical History:

Past Surgical History (excluding cesarean sections) Please provide the year.

D&C:_____ Bladder Repair:_____
Diagnostic laparoscopy:_____ Rectal Repair:_____
Hysteroscopy:_____ Cholecystectomy:_____
Conization of cervix:_____ Gastric Bypass:_____
Breast surgery:_____ Heart Surgery:_____

Please list ANY other surgeries and year they were performed.

Surgery	Year

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Please **CIRCLE** any of the following conditions that you currently or previously have had.

Asthma	Joint Pain	Mitral Valve Prolapse
Breast	Osteoporosis	Irregular Heart Beat
Breast Cancer	Arthritis	Murmur
Cervical Cancer	Endometriosis	High Cholesterol
Ovarian Cancer	Melanoma	Anemia
Colon Cancer	IBS	Phlebitis
PMS	Stomach Ulcer	Blood transfusion
Depression/Anxiety	Reflux	Hepatitis (A, B, C)
Uterine Fibroids	Eating Disorder	HIV/AIDS
Diabetes	Thyroid (hypo, hyper)	Kidney (stones, dialysis)
Lupus	Hypertension	Stroke

Family History:

Please mark an **X** to confirm the information below.

Mother: ( ) Living ( ) Deceased Cause:_____ Age of death:_____

Father: ( ) Living ( ) Deceased Cause:_____ Age of death:_____

	Mother	Father	Sister	Brother	Maternal GrandMother	Maternal GrandFather	Paternal GrandMother	Paternal GrandFather	Aunt
Breast Cancer									
Cervical Cancer									
Colon Cancer									
Lung Cancer									
Thyroid Cancer									
Ovarian Cancer									
Uterine Cancer									
Diabetes									
Heart Attack									
Hepatitis									
Hypertension									
Osteoporosis									
Stroke									
Thyroid Disease									
High Cholesterol									
Asthma									

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Social History:

Please fill out the information below.

Smoking Status: ( ) Current smoker, I smoke _____ Pack(s) per day since_____(year).
( ) Former smoker, (Yes) (No) I stopped in _____(year).
( ) I Have never smoked.

Alcohol Use: ( ) I currently drink, I drink _____ drink(s) per month.
( ) I quit prior to pregnancy.
( ) I am not a drinker.

Illicit Drug Use: ( ) I currently use_____ Drug_____times a week/month.
( )I have used_____drug in the past.
( ) I Have never used any illicit drugs.

Education Level: ( ) some high school ( ) some college
( ) high school grad ( ) college degree

Occupation:_____

Have you received the vaccine for chickenpox? _____ Have you ever had Chickenpox?_____

Living situation:

( ) Spouse ( ) Partner ( ) Alone ( ) Parent ( ) Other

Abuse: Current or previously, please explain below.

( ) sexual ( ) Physical ( ) Mental ( ) Drug

_____

_____

Genetic Family History:

Please consider both maternal and paternal (baby's mother and father) for this section

( ) Neural Tube Defect:_____
( ) Anencephaly:_____
( ) Congenital:_____
( ) Down's Syndrome:_____
( ) Other Trisomies:_____
( ) Tay-Sachs:_____
( ) Hemophilia:_____
( ) Sickle Cell disease or trait:_____
( ) Fragile X:_____
( ) Muscular Dystrophy:_____
( ) Mental Retardation:_____
( ) Other:_____

Age of the father of the baby:_____

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New Patient Medical History Form

Women's Health:

Have you ever had a sexually transmitted disease? (yes) (No) please circle one:

Gonorrhea Chlamydia HPV HIV HSV (Herpes) Genital warts Trichomonas's

Date of last pap smear:_____/_____/_____

Date of any past cervical procedures: (such as leep, cryo, colpo)_____

Past Obstetrical History:

( ) This is my first pregnancy:

Total number of pregnancies:_____Number of living births:_____

Number of miscarriages:_____ Number of elective abortions:_____ Number of tubal pregnancies:_____

(Please include all past pregnancies INCLUDING any miscarriages, abortions, and ectopic pregnancies.)

Date	Weeks Pregnant	Type of Delivery	Birth Weight	Infant Sex	Complications in delivery?

*Type of delivery: Vaginal, C-section, abortion, miscarriage

*Complications in delivery examples: hemorrhage, abruption, seizure, shoulder dystocia

If you have had a C-section, please list the reason why:_____

Have you ever had gestational diabetes with any past pregnancies?_____

Have you ever had preeclampsia or PIH with any past pregnancies?_____

Have you ever had a Vaginal Birth After Cesarean delivery (VBAC)?_____

Were you sent to Maternal Fetal Medicine (high risk) for any concerns during any of your past pregnancies? If so, please explain.

_____

_____

_____

I have reviewed the above history forms and have completed all fields to the best of my knowledge.

Patient's Signature:_____ Date:_____/_____/_____