ARBOR OBGYN PRECONCEPTIONAL HEALTH ASSESSMENT Chart No:

Date:		Referred by:			
Name:		Address:			Phone:
Age	DOB	Race	Religion		
Occupation		Employer		Ht	Wt
Partner Name:					

What is your main interest in seeking preconceptional counseling:

In order that we can address your specific interests and concerns, we ask that you complete the following questionnaire. You may use the reverse sides of the form to provide additional information when necessary. Please check YES or NO

		SOCIAL HISTORY
YES	**NO**	***Do you:***
		Drink beer, wine or hard liquor
		Smoke cigarettes or use any other tobacco products
		Use marijuana, cocaine or any recreational drugs
		Use lead or chemicals at home or at work. If YES, list the specific chemicals if you know them:
		Work with radiation
		Participate in an exercise program
		Are you 34 years of age or older
		NUTRITIONAL and MEDICATION HISTORY:
		On the reverse side of this sheet, list by meal everything you ate and drank yesterday, including the approximate amount; indicate snacks separately:
YES	**NO**	***Do you:***
		Practice vegetarianism
		Supplement with vitamins? If yes, list vitamins and dosages:
		Take medications including oral contraceptives. If so, please list names and dosages:
		Routine or occasionally take over-the-counter medications? If yes, list names and dosages: _____ _____ Have an intolerance to milk
		REPRODUCTIVE HISTORY:
		Number of time you have been pregnant: _____ Number of living children:_____
YES	**NO**	***Do you have a history of:***
		Uterine or cervical abnormalities
		Two or more pregnancies that ended in first trimester miscarriages
		One or more pregnancies that ended between 14 and 28 weeks of gestation
		One or more fetal deaths
		One or more infants who weighted less than 5½ pounds at birth
		One or more infants with a birth defect

FAMILY HISTORY		
YES	**NO**	***Do you or your partner, or members of either of your families, including offspring have:***
		Hemophilia
		Thalassemia
		Tay-Sachs disease
		Sickle-cell disease or trait
		Phenylketonuris (PKU)
		Cystic fibrosis
		Birth defects
		Mental retardation
		Are you and your partner related outside of marriage (such as cousins)
		Are you or the baby's father of Eastern European (Ashkenazi) Jewish ancestry
		Are you or the baby's father black
		If yes, have either of you been screened for sickle cell disease
		If yes, indicate who and the results:
		Are you or the baby's father of Italian, Greek, Mediterranean, Philippine or
		Southeast Asian ancestry background

MEDICAL HISTORY		
YES	**NO**	***Do you now have, or have you ever had:***
		Diabetes
		Thyroid Disease
		Phenylketonouria (PKU)
		Asthma
		Heart Disease
		High Blood Pressure
		Deep venous Thrombosis (blood clot)
		Kidney Disease
		Systemic lupus erythematous (SLE)
		Epilepsy
		Sickle Cell Disease
		Cancer
		Other health problems that require medical or surgical care. If yes, describe:

INFECTIOUS DISEASE HISTORY		
YES	**NO**	***Do you or your partner have a history of:***
		Recurrent genital infections
		Herpes simplex
		Chlamydia infection
		Human papilloma virus (genital warts)
		Gonorrhea
		Syphilis
		Viral hepatitis or high risk behaviors, including use of IV street drugs or intimate with anyone with those habits?
		Bisexual/ homosexual contact or multiple partners
		AIDS or high risk behaviors including use of IV street drugs or intimate with anyone with those habits?
		Occupational exposure to the blood or bodily secretions of others
		Blood transfusions
		Do you:
		Own or work with cats
		Have documented immunity to rubella
		Have a history of chicken pox

PARTNER HISTORY		
YES	NO	Partner Age:_____ Race: _____ Occupation:_____ Employer_____ ***Does your partner have a history of:***
		Any medical problems:
		Surgery:
		Tobacco Use
		Alcohol Use
		Drug Use
		Has your partner fathered any children?
		Does your partner have erectile or ejaculatory difficulties Is your partner exposed to lead, radiation or chemicals at work or home? If yes, please list:
		Does your partner take any medications. If yes, please list:

FOR PROVIDERS ONLY
RECOMMENDATIONS:
Rubella:
Dietary Consult:
CF:
MFM Consult:
Other: