

Welcome to the Maternal & Infant Care Clinic at the University of Washington Medical Center. In order to provide you with obstetric care, we ask that you please provide the information requested here. We want to assure you that this information is kept confidential.

Name: _____ Age: _____ Date: _____

What is your reason for coming to this office visit today?

Have you had any of the following? If the answer is yes, then please give details like when and what treatment was done.

YES	NO		When/What
_____	_____	Anemia, bleeding, or other blood problems	_____
_____	_____	Arthritis	_____
_____	_____	Asthma or breathing problems	_____
_____	_____	Blood clots	_____
_____	_____	Cancer	_____
_____	_____	Cataracts or glaucoma	_____
_____	_____	Depression	_____
_____	_____	Diabetes	_____
_____	_____	Heart disease or heart murmur	_____
_____	_____	Hepatitis (jaundice or yellow skin)	_____
_____	_____	High blood pressure	_____
_____	_____	Liver Disease	_____
_____	_____	Kidney or bladder problems	_____
_____	_____	Seizures (epilepsy)	_____
_____	_____	Stroke	_____
_____	_____	Suicidal thoughts or attempts	_____
_____	_____	Tuberculosis or a positive skin test	_____
_____	_____	Thyroid problem	_____
_____	_____	Ulcer or bowel/stomach problems	_____

Are you currently on any medications (including non-prescription medicines)? NO ____ If yes, list below:

Drug Name	Dosage
_____	_____
_____	_____
_____	_____

Are you allergic to any medications? NO ____ If yes, please list below:

Drug Name	Type of reaction when you took the drug
_____	_____
_____	_____

Please list all of your **past operations, injuries, or major illnesses** below:

Year	Problem or Operation	Doctor or Hospital
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

MENSTRUAL CYCLE

YES _____ NO _____ Do you have menstrual periods?
How old were you when you had your first period? _____
When was your last period? _____
If you do not have periods, why not? _____

YES _____ NO _____ Are your periods regular?
How often do you have a period? _____

YES _____ NO _____ Have you ever had difficulty getting pregnant?

PREGNANCIES

Please describe your pregnancies below. Check here if you have never been pregnant _____

Delivery Date	Term/Preemie	Vaginal or Cesarean	Hours of Labor	Weight	Hospital
Example: 3/24/68	40 weeks	vaginal	15 hours	7 lb. 12 oz.	University
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____

How many miscarriages have you had? _____ How many abortions have you had? _____