



Health History - Page 1

NAME _____ Date: _____ Code _____

Surgeries & Hospitalizations:

YEAR:	REASON/OUTCOME:

General Health History: ****NOT**** Pregnancy Related

Condition:	Comments:	Condition:	Comments:
<input type="checkbox"/> Food Allergies		<input type="checkbox"/> Diabetes	
<input type="checkbox"/> Non-Food Allergies		<input type="checkbox"/> Hypoglycemia	
<input type="checkbox"/> Anorexia/Bulimia		<input type="checkbox"/> Hypertension	
<input type="checkbox"/> Dental Problems		<input type="checkbox"/> Heart Prob./Murmur	
<input type="checkbox"/> Severe Headaches		<input type="checkbox"/> Blood Clotting Prob.	
<input type="checkbox"/> Arthritis/Joint Issues		<input type="checkbox"/> Asthma/ Lung Prob.	
<input type="checkbox"/> Stomach Prob./Ulcers		<input type="checkbox"/> Anemia/Bruise Easy	
<input type="checkbox"/> Digestive/Bowel Prob.		<input type="checkbox"/> Tuberculosis	
<input type="checkbox"/> Back or Hip Injury		<input type="checkbox"/> Skin Problems	
<input type="checkbox"/> UTI/Kidney Prob.		<input type="checkbox"/> Epilepsy/Seizures	
<input type="checkbox"/> Liver Cond./Hepatitis		<input type="checkbox"/> Cancer/Chemo/Radiation	
<input type="checkbox"/> Steroid Therapy		<input type="checkbox"/> Rheumatic Fever	
<input type="checkbox"/> Gall Bladder Prob.		<input type="checkbox"/> Psycho/Emotional Issues	
<input type="checkbox"/> Eye/Vision Prob.		<input type="checkbox"/> Insomnia	
<input type="checkbox"/> Dizziness		<input type="checkbox"/> Thyroid Issues	
<input type="checkbox"/> Varicosity/Hemorrhoid		<input type="checkbox"/> Ear/Hearing Prob.	

- Y N** Have you or the father of your baby ever had a baby with birth defects or retardation?
- Y N** Do you or the father of your baby have family members with genetic conditions?
- Y N** Are you and the baby's father related by blood, ie cousins?
- Y N** Have you ever experienced dramatic fluctuations in your weight?
- Y N** Were you immunized as a child?
- Y N** Have you ever been told that you were using drugs or alcohol excessively?
- Y N** Have you ever been in a relationship in which you were physically or emotionally intimidated or injured?
- Y N** Have you ever had non-consensual sex, or worked as a sex worker?
- Y N** Have you ever used drugs intravenously?
- Y N** Have you ever regularly used street drugs?
- Y N** Do you think you are at an increased risk of HIV/AIDS?
- Y N** Do you feel that you need counseling regarding any of the mentioned issues?
- Are you or the father of this baby from any of these ethnic/racial groups?
- Ashkenazi Jewish African Asian Aleutian Mediterranean