Women's Health Connecticut
CCOG Women's Health Group
Member of Women's Health Connecticut

Devoted to women, committed to excellence.

Obstetrics and Gynecology
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PLEASE COMPLETE AND RETURN TO OUR OFFICE

Full Name:_____ Maiden Name: _____

Date of Birth:_____

Address: _____

Home Phone#:_____ Last 4 of Social Security #: _____

Work Phone#:_____ Marital Status _____

Age at first menstrual period:_____

How long are your menstrual cycles? (Number of days from one period to the next) _____

How many days does your period last?_____ Are they regular?_____

Was this pregnancy planned?_____ If so, months attempted: _____

When did your last period begin? _____ Was it normal?_____

If not normal, how was it unusual? _____

Date of positive pregnancy test: _____

List all previous pregnancies, including abortions and miscarriages:

Month/Yr	How far along were you?	Length of Labor	Vaginal or Cesarean	Place of Delivery	Boy or Girl	Wt of baby

1. _____

2. _____

3. _____

4. _____

5. _____

Are all your children still living? _____

Any complications of delivery or problems in previous pregnancies?

_____

Check if you have had any of the following: ☐ List dates and treatments:
Please check this box if you have had none: ☐

Diabetes _____
Hypertension _____
Heart Disease _____
Autoimmune disorder _____
Kidney/UTI _____
Neurologic/Epilepsy _____
Psychiatric _____
Depression _____
Hepatitis/Liver Disease _____
Varicosities/Phlebitis _____
Thyroid Dysfunction _____
Trauma/Violence _____
History of Blood Transfusion _____

Rh Sensitized (Blood Type) _____
Asthma/TB _____
Allergies(drug/latex) _____
Breast _____
GYN Surgery _____
Operations/Hospitalizations _____
Anesthetic Complications _____
History of Abnormal Pap _____
Infertility _____
Uterine Anomaly/DES _____
ART Treatment _____
Relevant Family History _____
Other _____

_____

INFECTION HISTORY

Please check below if you have any of the following:
Please check this box if you have none: ☐

High Risk for HIV ☐
High Risk for Hepatitis B ☐
Have you been immunized for Hepatitis B ☐
Live with someone with or exposed to TB ☐
Patient or partner has history of genital herpes ☐
Rash or viral illness since last menstrual period ☐
History of STD, GC, Chlamydia, HPV or Syphilis ☐
Other _____

Symptoms since last menstrual period: _____

Medications since last menstrual period: _____

Please check below if you have the following:
Please check this box if you have none: ☐

Patient's age- over 35 ☐
Thalassemia (Italian, Greek, Mediterranean Or Asian background) ☐
Neural Tube Defect ☐
Congenital Heart Defect ☐
Down Syndrome ☐

Huntington Chorea ☐
Mental Retardation ☐
If yes was person tested for fragile X? _____
Other inherited genetic or chromosomal disorder ☐
Maternal Metabolic Disorder (Eg, Maternal Type 1 Diabetes, PKU) ☐

Tay Sachs (EG, Jewish, Cajun, French or Canadian) ☐
Canavan Disease ☐
Recurrent pregnancy loss/stillbirth ☐
Hemophillia ☐
Cystic Fibrosis ☐
Other _____

Patient or baby's father had a child with a defect not listed above ☐
Familial dysautonomia ☐
Sickle Cell ☐
Muscular Dystrophy ☐
Medication/Alcohol/Street drugs since your last menstrual period ☐

Patient's Primary Language:_____ Education: _____

Patient's Place of Birth: _____

Patient's Ethnicity_____ Religion: _____

Patient Employer:_____ Patient Occupation: _____

Father of Baby:_____ Father's ethnicity:_____

Does the father of the baby have any health issues?_____

Name of emergency Contact:_____

Emergency Contact phone number#_____ Relationship:_____

Pediatrician for baby: _____

	AMT/DAY	AMT/DAY	#YEARS
Tobacco	PRE/PREG_____	PREG_____	USED _____
	AMT/DAY	AMT/DAY	#YEARS
Alcohol	PRE/PREG_____	PREG_____	USED _____
	AMT/DAY	AMT/DAY	#YEARS
Caffeine	PRE/PREG_____	PREG_____	USED _____
	AMT/DAY	AMT/DAY	#YEARS
Drugs:	PRE/PREG_____	PREG_____	USED _____

Do you exercise?_____ Frequency:_____

Type of exercise: _____ Do you have a gym membership?_____

Do you have any hobbies?_____

Do you have any of the following in the home?

Firearms ☐
Cats ☐
Smoke Detectors ☐
Carbon monoxide detectors ☐
Radon ☐

Do you wear your seatbelt? _____

What is your height? _____ What was your pre pregnancy weight? _____