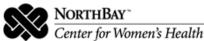
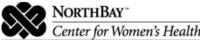


NAN	ЛЕ:					DATE O	F BIRTH:			ner jer mennen	
OBSTETRICAL HISTORY					Height:			Weight:			
PRE	GNANCIES:	(Outcome	is vaginal delive	ry, cesare	ean, misc	arriage, al	ortion or ed	ctopic)	Pre-Pregna	ancy weight:	
#	Date (M/D/Y)	Outcome	Gestational Age (week)	Gender M / F	Living now?	Birth Weight	Vacuum/ Forcep	Preterm Under 37 weeks	Anesthesia Epidural or IV meds	Labor Length Days/Hours	Twins
1								Weeks			
2											
3											
4											
5											
6											
_	I ITIONAL PI	REGNANCY	INFORMATION								
Was	this pregnai	ncy:	Planned / Unplan	ned	-	ou on horn 2 months o	nonal contract	c eptives O / YES	Breastfeedi Conception		
			lity treatment: N		D-I-4'-			F.al.		- 42 VEC / NO	
Supp	ort Person's	s Name:			Relatio	nsnip:		Fathe	r of baby involv	ed? YES / NO	
Is thi	is baby up fo	or adoption:	NO / YES	Is this a	surrogate	e pregnanc	y: No	O / YES			
	NING LUCTO	DV AND DI									
		RY AND PL		□NO	□ Neve	r breastfed	hefore				
		_	□ Exclusively brea					Breastfed wit	h formula suppl	ementation	
	ious i ccume		 □ Exclusively forr 		•	-			iii Torriidid Sappi	ementation	
Leng	th of previo	us breastfee									
		eeding issues		_		,		Plans	for breastfeedi	ng this baby:	
□ No	ne			□ Multi	ple birth c	delivery		□ Bre	ast milk		
	east Surgery				n to work			□ For			
	ngenital And		7 wooks		cess to nu	ıtritional I a	idvice		astmilk/formula		
<u> </u>			□ Pain					bottle to baby decided			
	ck of support			□ Poor		201101113111			acciaca		
□ Les	ss than 1 yea	ır since last p	regnancy		milk suppl						
	aternal stress	S			ological fa						
	edical issue om and baby	cenarated		□ other	:						
⊔ IVIC	oni and baby	separateu									
ALLE	ERGIES (Sub	ostance and	Reaction)			□ Latex	Allergy? Re	eaction:			
			ON / SEDATION adverse reactions		NO.	Anastha	cia/Trancfuci	on history (H	ave vou ever had	d a complication?	١
	,	unestinesia (.0	□ Not ap			or transfusion	a a complication.	,
						□ Prior a	nesthesia rea	action 🗆 Prio	or transfusion re	action	
								_	known		
Mod	erate sedati	on history		Droblor	ns with se		reaction:				
	prior sedati	-		□ None		□ Vomiti	ng 🗆	Other:			
	or sedation			□ Naus	ea	□ Unkno					
							_				
<u>TRA</u>	<u>NSFUSION</u>		Is a blood trans		-						
			If NO, what is th	ne blood	retusal re	eason: 🗆 R	eligious Rea	sons 🗆 Otl	ner:		
MEC	<u>DICATIONS</u>	(Please list	all medications	you are c	urrently	taking)					
				Dose: _			Route:				
				Dose: _			Route:		Frequency:		
				Dose: _			Route:				
				בסטבי			Route:		riequency:		



				Come je.		
	ver had any of the following? If Y	•				
Asthma Yes /		Yes / No	Rh Negative		'es / No	
Anxiety Yes /	No Hepatitis	Yes / No	Seasonal alle	-	'es / No	
Autoimmune Disease Yes /	,	ap Yes / No	Thyroid Dise	ase Y	'es / No	
Breast Yes /	No Hypertension	Yes / No	Trauma	Υ	'es / No	
Depression Yes /	No Kidney disease	Yes / No	Tuberculosis		'es / No	
Diabetes Yes /	No Liver Disease	Yes / No	UTI (Urinary	tract infections) Y	'es / No	
Gestational Diabetes Yes /	No Phlebitis	Yes / No	Uterine	Υ	'es / No	
Epilepsy Yes /	No Postpartum Depressio	n Yes / No	Varicosities		es / No	
Gynecological Surgery Yes /	No Psychological Problem	s Yes / No	Do you have	cats Y	es / No	
			Other:			
Operations/Hospitalizations (Ple	ase list year and procedure)					
	ever had any of the following?)					
\sqsupset Live with someone with TB or ex			☐ History of			
$\ exttt{ iny}$ You or your partner have history	• .	_	☐ History of			
☐ Rash or viral illness since LMP	☐ History of		☐ History of	ry of varicella		
	☐ History of	HPV	□ Other:			
MMEDIATE FAMILY HISTORY	Please indicate who (Mother, Fath	ner, Child, Sibling, Ma	ternal or Pater	nal Grandparent	ts)	
Cardiovascular	Endocrine/ Metabolic	Gastrointestinal		Musculoskeletal		
Congestive heart failure	Diabetes type 1	Colitis		Arthritis		
Coronary artery disease	Diabetes type 2	Crohn's disease		Osteoporosis		
Heart disease	Obesity	Ulcerative colitis		Rheumatoid arth	ritis	
High blood pressure	Thyroid disease					
High cholesterol	,					
Neurologic	Oncologic	Psychiatric		Respiratory		
Alzheimer's disease	Breast cancer		ADD-Attention deficit disorder			
Dementia	Colon cancer		Alcoholism			
Migraine	Ovary cancer	Anxiety		COPD Cystic fibrosis		
Seizures	Prostate cancer	-		Tuberculosis		
Tremors	Prostate cancer Bipolar Tuberc Gastric cancer Depression		raberealosis			
Tremors	Renal cancer	-	Suicide			
	Renarcancer	Juiciac				
COCIAL LUCTORY						
SOCIAL HISTORY	50 NO 0 10 1	0 '1 1 1 1				
Have you ever smoked?		Quit Last used:			2	
Type: Cigarettes Oral Oth		low many packs per day	/? F	or now many year	S?	
Does anyone smoke in the house	hold? □ YES □ NO					
Do you drink alcohol?	ES 🗆 NO 🗆 Occasional 🗆	In past If yes	s, how many drir	nks per week?		
Type: □ Beer □ Wine □ L	iquor					
Do you now use or have you ever	used recreational drugs? NO	YES 🗆 In past If	yes, what drugs	?		
Started at age: years Sto	pped at age: years L	ast used:	IV drug use	e: □ YES □ NO		
Is there someone in the househo	ld with substance abuse? ☐ YES ☐	□ NO				
Who lives with you at home? A	lone □ Spouse □ Children					
What is your living situation: □ H	ome/Independent □ Home wi	ith assistance 🗆 Ho	meless/Shelter	□ Other:		
Is there abuse or neglect in the h	ousehold? YES If Yes, what type:	□ NC)			
Family and friends available to he	elp? □ YES □ NO					
	ires (i.e., Pesticides, chemicals, radiat	tion) 🗆 YES		🗆 NO		
Are you sexually active?						
	tation? 🗆 Lesbian, gay or homosexua	l □ Straight □ Bisexual	□ Don't know □	Choose not to dis	sclose Other:	
	tity? Male Female Female					
, and the second	•	Other:		-1. 22. (
Do you use condoms? ☐ Alwa		 	_			
Other contraceptive use?		e 🗆 IUD 🗆 Oti	her:			
Any history of sexual abuse?	•	2.02				
Date of your last pap:		ial pap? □ NO □ VF	S When?	Treatment	٠,	
	rtum? Oral IUD Implant			rreatment	···	
Dittil control preference post-pa	a orar a rob a implant	jeedon		_		



Do you exercise? □ NO □ YES	Type of exercise:		How many times	s per week?
What is your occupation?		□ Part-time □ I	Full-time	
Activity level: □ Desk/ Office	□ Moderate	□ Heavy		
What is your highest education level	l? □ High school □ S	Some college 🗆 l	Jniversity degree ☐ Post gr	aduate degree 🗆 Other
COMMUNICABLE DISEASE				
Have you been treated for TB in the p				
Have you ever received prophylactic t	reatment for positive	ΓΒ? □ NO □ Y	ES If yes, please explain:	
Did you ever receive Bacille Calmette-				
Го your knowledge, have you been ex	posed to any commun	icable disease in t	the past 6 weeks?	□ YES □ Unknown
Have you or family member traveled o	outside the U.S in the p	past 6 months?	□ NO □ YES If yes, where	?
MENSTRUAL HISTORY		, ,	W this a said document	- NO - VEC
When was the first day of your last mo			Was this period normal?	□ NO □ YES
Menarche onset:				
What is the date of your menstrual pe	eriod prior to the last?	//	Date of home pregnancy te	St!/
GENETIC HISTORY				
What is your ethnic background?	□ African □ Asian	□ Caucasian	☐ Filipino ☐ Hispanic	□ Other:
ather of the baby's ethnic backgrou	nd?African □ Asian	□ Caucasian	□ Filipino □ Hispanic	□ Other:
Birth defect	□ None	∃ Self	□ Baby's Father	□ Other:
Canavan disease	□ None	□ Self	□ Baby's Father	□ Other:
Congenital heart disease	□ None	□ Self	□ Baby's Father	□ Other:
Cystic fibrosis	□ None	∃ Self	□ Baby's Father	□ Other:
Down syndrome	□ None	□ Self	□ Baby's Father	□ Other:
Hemophilia	□ None □	∃ Self	□ Baby's Father	□ Other:
Huntington's chorea	□ None	□ Self	□ Baby's Father	□ Other:
Maternal metabolic disorders	-		□ Baby's Father	□ Other:
Mental retardation/Fragile x	□ None	□ Self	□ Baby's Father	□ Other:
Muscular dystrophy	□ None	∃ Self	□ Baby's Father	□ Other:
Neural tube defect	□ None □	∃ Self	□ Baby's Father	□ Other:
Recurrent pregnancy loss or stillbirths	s □ None □	∃ Self	□ Baby's Father	□ Other:
Sickle cell disease	□ None	Self	□ Baby's Father	□ Other:
Гау sachs	□ None	∃ Self	□ Baby's Father	□ Other:
Гhalassemia	□ None	□ Self	□ Baby's Father	□ Other:
Other:				
Any Cystic fibrosis screening in th	e past? 🗆 NO 🗆	∃ YES, please exp	olain:	
_				
Preferred pharmacy name and ad	ldress:			
Patient Signature:			Date of Compl	etion.