AMOMI

PREGNANCY WELLNESS ~ SPA

Date: _____ **Patient #** _____
Name: _____ **LMP** _____
DOB: _____ **EDD** _____

Patient Signature: _____

ALLERGIES:

Are you allergic to any medications/latex/foods?

- ☐ No
- ☐ Yes
- ☐ If Yes, please list medication(s) and reaction(s):

PAST MEDICAL HISTORY:

Please mark any condition you have or had in the past:

- ☐ Cancer
- ☐ Epilepsy
- ☐ Heart Disease
- ☐ High Blood Pressure
- ☐ Kidney Disease
- ☐ Hepatitis
- ☐ Bleeding disorder/(von Willebrand Disease)
- ☐ Blood Clotting Disorder/DVT/PE)
- ☐ HIV/AIDS
- ☐ Thyroid Disorder
- ☐ Headaches
- ☐ Arthritis/Lupus
- ☐ Frequent Infections
- ☐ Bowel Disease
- ☐ Diabetes
- ☐ Eating Disorder
- ☐ Depression/Mental Health Disorder
- ☐ Asthma
- ☐ Anemia
- ☐ Herpes
- ☐ Sexually Transmitted Infection
- ☐ Recurrent Urinary Tract Infection

Please describe any health problems or symptoms that you are having at this time:

Any fever, rash, or viral illnesses since becoming pregnant?

PAST SURGICAL HISTORY:

Please indicate any prior surgery or hospitalizations:

OB/GYN HISTORY:

Pregnancy History

Date (Mo/Yr)	GA (Weeks)	Labor Duration	Birth Weight	Sex	Type of Delivery	Anesthesia	Place of Delivery	Complications?

GYN History

When was your last pap test?

Have you ever had an abnormal pap test?

- ☐ No
- ☐ Yes
- ☐ If yes, when and how were you treated?

Have you ever had a sexually transmitted infection?

- ☐ No
- ☐ Yes

If yes, please indicate which infection:

- ☐ Chlamydia
- ☐ Gonorrhea
- ☐ Syphilis (Please describe treatment):
- ☐ Herpes (Last outbreak):

Have you ever used an IUD?

- ☐ No
- ☐ Yes
- ☐ If yes, when:
- ☐ Any problems?

Have you been treated for infertility?

- ☐ No
- ☐ Yes
- ☐ If yes, please describe treatment(s):

PSYCHOSOCIAL HISTORY

Are you on a restricted diet?

- ☐ No
- ☐ Yes
- ☐ If yes, please explain:

Do you smoke cigarettes?

- ☐ No
- ☐ Yes
- ☐ If yes, how many packs per day? Second-hand smoke?
- ☐ If recently quit, when?

Do you drink alcoholic beverages now, or before pregnancy?

- ☐ No
- ☐ Yes
- ☐ If yes, how often/what types of drinks:

Please list any recreational drugs used since your last period: (e.g. marijuana, cocaine, others)

List any medications taken since your last period: (Prescriptions, over-the-counter medicines, vitamins, herbs, or supplements)

Are you ever exposed to chemicals or radiation (X-rays)?

- ☐ No
- ☐ Yes
- ☐ If yes, please describe:

Do you have religious objections to any form of medical treatment? (E.g. refusal of blood transfusion, others)

- ☐ No
- ☐ Yes
- ☐ If yes, please describe:

PERSONAL STRESS

Do you have any problems that might prevent you from keeping appointments?

Do you feel unsafe where you live?

In the past year, have you been threatened, hit, slapped, or kicked by anyone?

Has anyone forced you to perform any sexual act that you did not want to do?

Do you have reason to believe you have been exposed to HIV, TB, or Hepatitis?

On a 1-5 scale, how do you rate your current stress level? 1(low)/5(high)

How many times have you moved in the past 12 months?

FAMILY/GENETIC HISTORY

Your Background

	Yourself	Baby's Father
Age		
Ethnic Origin		
Religion		
Occupation		

Does your family or the father of the baby's family have the following background?

	YES	NO
SE Asia, Taiwan, China, Philippines		
Italy, Greece, or Middle East		

If yes, have you or your partner been tested for thalassemia?

	YES	NO
Eastern European Jewish (Ashkenazi)		
French Canadian		

If yes, have you or your partner been tested for Tay Sachs or Cystic Fibrosis?

	YES	NO
African American, African, Black		

If yes, have you or your partner been tested for sickle cell anemia?

Have you, the baby's father, or anyone in either of your families had any of the following?

YES	NO	DISORDER
		Down Syndrome
		Chromosome Abnormality
		Neural Tube Defect (Spina Bifida or Anencephaly)
		Hemophilia or other bleeding disorder
		Cystic Fibrosis
		Sickle Cell Anemia
		Thalassemia
		Tay Sach's Disease
		Muscular Dystrophy
		Neurofibromatosis
		Huntington's Disease
		Seizure Disorder (Epilepsy)
		Other Nerve/Muscle Disorder
		Phenylketonuria (PKU)
		Kidney Disease
		Heart Defect (from birth)
		Cleft lip or palate
		Limb defect (extra/missing digits, malformed arms/legs or hands/feet)
		Deafness/Early onset hearing loss
		Blindness/Early onset vision loss
		Diabetes
		Cancer before age 50
		Heart attack before age 40
		Mental Retardation/Developmental Delay
		Autism
		Problems with Anesthesia

Have you or the baby's father had a baby that died shortly after birth or in the first year?

- ☐ No
- ☐ Yes
- ☐ If yes, please describe:

Are you and the baby's father blood-related in any way? (cousins, uncle/niece, etc.)

- ☐ No
- ☐ Yes
- ☐ If yes, please describe:

PEDIGREE (if needed):