PROGRESSIVE
WOMEN'S HEALTH

499 Farmington Ave | Suite 220 | Farmington, CT 06032

Initial Pregnancy Visit History Form

Welcome to Progressive Women's Health obstetrical care! Please complete this confidential record of your medical history. The information you provide here will help us as we care for you during your pregnancy. Please take the time to fill it out as completely as possible, and **bring the completed form to your visit**. Thank you!

Are you currently experiencing any of the following?

☐ Change in appetite?	☐ Fatigue?
☐ Fever?	☐ Headache
☐ Cough	☐ Shortness of breath?
☐ Frequent upper respiratory infections?	☐ Snoring?
☐ Wheezing?	☐ Chest pain or palpitations?
☐ Edema or swelling?	☐ Fainting spells?
☐ Abdominal pain?	☐ Blood in stools?
☐ Constipation?	☐ Heart burn?
☐ Weight loss?	☐ Burning with urination?
☐ Urinary frequency?	☐ Leaking urine?
☐ Painful periods	☐ Heavy periods?
☐ Breast lumps or pain?	☐ Vaginal itching?
☐ Vaginal discharge?	☐ Headaches?
☐ Light headedness?	☐ Acne?
☐ Contact allergies?	☐ Rash?
☐ Back or joint pain?	☐ Easy bleeding?
☐ Blood clots in the legs, lungs, brain, heart?	☐ Hay fever?
☐ Environmental allergies?	☐ Food allergies?

Comments: ____

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Pregnancy History:

How many pregnancies have you had? _______ How many living children do you have? _____

Number of vaginal births? _______
Number of cesarean births? ______
Number of miscarriages? ________
Number of abortions? ___________

Month & Year of birth or miscarriage	Pregnancy Age at Birth (weeks or months)	Hours in Labor	Birth weight	Place of delivery	Vaginal or cesarean?	Sex of baby	Anesthesia & Type (epidural?)

Menstrual History:

How old were you when your period started? ______________________

Have your periods been regular or irregular? _______________________________

Were you on any birth control when you got pregnant? Yes No

If yes, what?____

Date of positive home pregnancy test? _____________________________

Symptoms since your last period?

- ☐ Abdominal cramps?
- ☐ Swelling/edema?
- ☐ Headaches?
- ☐ Vomiting?
- ☐ Infection or chemical exposure?
- ☐ Vaginal discharge?
- ☐ Breast tenderness?
- ☐ Fevers?
- ☐ Nausea?
- ☐ Radiation exposure i.e. xrays, CT scan?
- ☐ Vaginal bleeding?
- ☐ Other symptoms?

Your Medical/Surgical History:

☐ Diabetes ____
☐ High blood pressure ______________________________________
☐ Heart disease ____
☐ Autoimmune disorder (M.S., Lupus, etc) _____________________
☐ Kidney disease (infection, stones) or frequent urine infections ____________
☐ Seizures, epilepsy, or neurological problems ___________________
☐ Depression, anxiety, or other mental health disorders ______________
☐ Postpartum depression ____________________________________
☐ Hepatitis or liver disease __________________________________
☐ Varicose veins, phlebitis __________________________________
☐ Thyroid disease ____
☐ Trauma or violence ______________________________________
☐ History of blood transfusions _______________________________
☐ Tobacco use: Packs per day before pregnancy? _________ Currently? __________
☐ Alcohol use: Drinks per week before pregnancy? _________ Currently? __________
☐ Recreational drug use: Type: ________________________________
☐ Rh negative ____
☐ Drug or latex allergies ____________________________________
☐ Breast problems ____
☐ Gynecological surgeries ___________________________________
☐ Other hospitalization or surgery _____________________________
☐ Anesthesia complications __________________________________
☐ Abnormal Pap test _______________________________________
☐ Uterine anomaly or DES exposure ____________________________
☐ Infertility ____
☐ Other conditions ____

Infection History: *Have you are the father of your baby ever had any of the following infections?*

☐ Tuberculosis	☐ Gonorrhea
☐ Hepatitis B or C	☐ Chlamydia
☐ HPV	☐ Genital herpes
☐ HIV	☐ Rash with a viral illness
☐ Syphilis	

Please indicate your response by circling your answer or filling in the blank:

Do you plan to breastfeed? YES NO

Do you use a seatbelt? YES NO

Do you have cats in your home? YES NO

If a life threatening emergency, would you agree to a blood transfusion? YES NO

What is your ethnicity/race?____

What language(s) do you speak? ____

Which is your primary language that you speak at home?__________________________

What is your highest education level? ____

What is your occupation? ____

What is your religion? ____

Is the father of the baby supportive of your pregnancy? YES NO

Father of the baby's name:____

Father of the baby's
ethnicity/race:____

Father of the baby's occupation:____

Who shall we contact in case of emergency & at what phone #? ____________________

____

Who is your pediatrician (if you have one): ____________________________________

<u>Genetic Screening:</u> ***Please indicate if any of these conditions are present in your family or the father of the baby's family.***

	You	Father of the baby	Family Member of you or Father of baby
Thalassemia			
Neural Tube Defect			
Heart defects			
Down syndrome			
Tay Sachs disease			
Canavan disease			
Familial dysautonomia			
Sickle cell disease or trait			
Hemophilia or other blood disorders, including clotting disorders			
Muscular dystrophy			
Cystic fibrosis			
Huntington's disease			
Intellectual Disability, Mental Retardation or Autism			
Other inherited disorder or birth defect			

Thank you for taking the time to help us care for you during your pregnancy. We look forward to assisting you in having the healthiest pregnancy possible!

Ursula Steadman, MD
Rachel LaMonica, DO
Cristina Dinicu, MD
Alison Birdsey, Certified Nurse Midwife
Nicole Charest, RMA
Ashley Allan, CMA
Jelany Fontanez, RMA
Kristyn Rouleau, CMA
Ana Pomales, RMA
Naomi Delgado-Onisto, Medical Receptionist
Mersiha Kuljancic, Medical Receptionist/Scheduler
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