Pelvic to Confirm

Name:	Date of Birth:
Date of LMP:	

Current Medications (include hormones, herbs, vitamins, nonprescription medicine)	
Name and Dosage	Name and Dosage
1.	4.
2.	5.
3.	6.

Allergies (please include all drug allergies)	
1.	3.
2.	4.

What is your problem today: late of menses, irregular menses, abnormal uterine bleeding, positive home pregnancy test, negative home pregnancy test

Have you used the pill Depo-Provera recently? **Yes** **No**

Was your last period normal? **Yes** **No**

Did you take a pregnancy test when you thought you were late? **Yes** **No** **When?** _____

Any problems thus far this pregnancy? (circle or write below)

Nausea **Weight Gain** **Weight Loss** **Breast Tenderness** **Pain** **Cramping** **Vomiting**
Other:

Since Your Last Visit:	**Yes**	**No**	**Please Describe:**
Have you been diagnosed with a new medical problem?			
Have you had any surgeries?			
Have you been diagnosed with a new medication allergy?			
Do you have any new family history?			

Menstrual History	**YES**	**NO**
Date of your last menstrual period:		
Are your periods regular (28-30 days)?		
If No, what is the interval between your periods? (Number of Days)		
Do you have pain with your period?		
If Yes, how bad is that pain? Minimal Mild Moderate Severe		

Name_____ Age _____

CIRCLE “YES” or “NO” beside each of the following. If “YES”, please list which side of the family (Maternal or Paternal?), which relative, is it your family member or father of the baby’s family member, is it you or the father of the baby?

1) Thalassemia (inherited blood disorders. “Inherited” means passed from parents to children through the genes; Mediterranean region) NO / YES, explain:

2) Neural tube defect (an opening in the spinal cord or brain): NO / YES, explain:

3) Congenital heart defect (a defect in the structure of the heart and great vessels): NO / YES, explain:

4) Down Syndrome: NO / YES, explain:

5) Tay-Sachs (autosomal recessive genetic disorder): NO / YES, explain:

6) Canavan disease (autosomal recessive [2] degenerative disorder that causes progressive damage to nerve cells in the brain): NO / YES, explain:

7) Familial Dysautonomia (a disorder of the autonomic nervous system): NO / YES, explain:

8) Sickle cell disease or trait: NO / YES, explain:

9) Hemophilia or blood disorders: NO / YES, explain:

10) Muscular dystrophy: NO / YES, explain:

11) Cystic fibrosis: NO / YES, explain:

12) Huntington’s chorea (a neurodegenerative genetic disorder that affects muscle coordination and leads to cognitive decline and dementia): NO / YES, explain:

13) Mental retardation: NO / YES, explain:

14) Autism: NO / YES, explain:

15) Other inherited genetic chromosomal disorder: NO / YES, explain:

16) Maternal metabolic disorder (Type I diabetes, PKU, etc.): NO / YES, explain:

17) Have you or your family members, or father of the baby’s family members, had a child with birth defects not listed above? NO / YES, explain:

18) Recurrent pregnancy loss, or a stillbirth: NO / YES, explain:

Name_____ Age _____

Do you live with someone with TB or have you been exposed to TB? NO / YES, explain:

Do you or your partner have a history of genital herpes? NO / YES, explain:

Have you had a rash or viral illness since your last period? NO / YES, explain:

Do you or your partner have Hepatitis B or C? NO / YES, explain:

CIRCLE "YES" or "NO" if you or your partner have now (or have ever had) the following:

Chlamydia	NO / YES, explain:
Syphilis	NO / YES, explain:
HIV/ AIDS	NO / YES, explain:
Gonorrhea	NO / YES, explain:
Genital Warts	NO / YES, explain:
Pubic lice or crabs	NO / YES, explain:
Human Papilloma Virus ("HPV")	NO / YES, explain:
Trichomoniasis ("Trich")	NO / YES, explain: