Your Hospital's Logo Here

FAMILY PRACTICE

HEALTH HISTORY SUMMARY

Patient Name:
MR #: SSN#:
DOB: Age:
Address:

Home Ph #:
Race/Ethnicity: Religion:
Language:
Healthcare Provider: Mother's Education Level:

DEMOGRAPHIC DATA

Marital Status: ☐ M ☐ S ☐ W ☐ D Name of Baby's Father: ________ Age of Father: ________

Father's Education Level: ________

EMPLOYMENT DATA

Patient Employed: ☐ F/T ☐ P/T Occupation: ________ Work #: ________ ☐ Not Empl

Father of Baby: ☐ F/T ☐ P/T Occupation: ________ Work #: ________ ☐ Not Empl

MENSTRUAL HISTORY

Menarchy	Interval	Length	Positive Pregnancy	
Yrs: ________	Days: ________	Days: ________	Test: / /	☐ Blood ☐ Urine

LMP: / / Certain: ☐ Y ☐ N EDD by: ☐ Dates ______/______/______ ☐ Ultrasound ______/______/______ ☐ OCP ☐ No OCP

PREGNANCY HISTORY

Gravida:	Full Term:	Premature:	SAB:	VIP:	Ectopic:	Mult Births:	Live:

#	Month / Year	Infant Sex	Weight at Birth	Weeks Gestat'n	Hours in Labor	Type of Delivery	Anesthesia	Comments / Complications
1								
2								
3								
4								
5								
6								
7								

MEDICAL HISTORY

Check and detail POSITIVE FINDINGS below. Use reference numbers.

OBSTETRICS
1. ☐ Anemia
2. ☐ Fetal / Neonatal Death / Anomaly
3. ☐ Gestational Diabetes
4. ☐ Hemorrhage
5. ☐ Hyperemesis
6. ☐ Incompetent Cervix
7. ☐ Intrauterine Growth Retardation
8. ☐ Isoimmunization
9. ☐ Postpartum Depression
10. ☐ Preeclampsia / PIH
11. ☐ Preterm Labor or Birth
12. ☐ PROM - Chorioamnionitis
13. ☐ RH Neg

GYNECOLOGIC
14. ☐ Abnormal PAP
15. ☐ GYN Surgery / Cervical Surgery
16. ☐ Infertility

SEXUALLY TRANSMITTED DISEASES
17. ☐ Chlamydia
18. ☐ Gonorrhea
19. ☐ Herpes (HSV)
20. ☐ Syphilis

VAGINAL / GENITAL INFECTIONS
21. ☐ Trichomonas
22. ☐ Condylomata

OTHER INFECTIONS
23. ☐ Toxoplasmosis
24. ☐ Group B Streptococcus
25. ☐ Rubella
26. ☐ Chicken Pox
27. ☐ AIDS (HIV)
28. ☐ Hepatitis (Type ______)
29. ☐ Other ________________
30. ☐ Other ________________

PRINTED NAME:	SIGNATURE:	DATE:

HEALTH HISTORY SUMMARY

HOSPITAL - Family Practice

Patient Name: ____________________

MR #: ____________________

Check and detail POSITIVE FINDINGS below.
Use reference numbers.

	Patien	Family
CARDIOVASCULAR		
31. Heart Disease	☐	☐
32. Rheumatic Fever	☐	
33. Mitral Valve Prolapse	☐	
34. Chronic Hypertension	☐	☐
35. Variocosities Thrombophlebitis	☐	☐
36. Previous Pulmonary Embolism	☐	
37. Blood Disorders	☐	☐
38. Anemia / Hemoglobinopathy	☐	☐
39. Blood Transfusions	☐	
PULMONARY		
40. Asthma	☐	
41. Tuberculosis	☐	
42. Chronic Obstructive Pulmonary Disease	☐	☐
ENDOCRINE		
43. Diabetes	☐	☐
44. Thyroid Dysfunction	☐	☐
45. Other ____________	☐	
GASTROINTESTINAL		
46. Liver Disease		
47. Other ____________	☐	☐
RENAL DISEASE		
49. Cystitis	☐	
50. Pyelonephritis	☐	
51. Asymptomatic Bacteriuria	☐	
52. Chronic Renal Disease	☐	☐
NEUROLOGIC		
53. Seizure Disorder	☐	☐
54. Other ____________	☐	☐
OTHER		
55. Psychiatric Disease	☐	☐
56. Abuse or Neglect	☐	☐
57. Addiction (drug, alcohol, nicotine)	☐	☐
58. Major Accidents	☐	
59. Surgery	☐	
60. Anesthetic Complications	☐	
61. Non-Surgical Hospitalization	☐	
62. Medication Allergy -or- Sensitivities: (list below) ____________ ____________	☐	
63. Cancer	☐	
64. Autoimmune Disease	☐	
65. Other ____________	☐	☐
66. Other ____________	☐	☐

GENETIC HISTORY	Patien	Family	FOB
67. Age ≥ 35 (♀) or ≥ 50 (♂)	☐	☐	☐
68. Cerebral Palsy	☐	☐	☐
69. Congenital Anomalies	☐	☐	☐
70. Cystic Fibrosis	☐	☐	☐
71. Down's Syndrome	☐	☐	☐
72. Hemophilia	☐	☐	☐
22. Mental Retardation	☐	☐	☐
73. Muscular Dystrophy	☐	☐	☐
74. Neural Tube Defect	☐	☐	☐
75. Sickle Cell Disease / Trait	☐	☐	☐
76. Thalassemia A -or- B	☐	☐	☐
77. Other ____________	☐	☐	☐
78. Other ____________	☐	☐	☐

HISTORY SINCE LMP

PREGNANCY COMPLICATIONS	
1. Vaginal Bleeding	☐
2. Abdominal -or- Epigastric Pain	☐
3. Headache / Dizziness	☐
4. Change in Vision	☐
5. Hyperemesis	☐
6. Urinary Complaint	☐
7. Febrile Episode	☐
8. Rash with Viral Illness	☐
9. Physical Trauma -or- Surgery	☐
10. Other ____________	☐
EXPOSURE TO ENVIRONMENTAL TERATOGENS	
11. HIV, CMV, HSV, Syphilis	☐
12. Rubella, Varicella	☐
13. Encephalitis / Toxoplasmosis	☐
14. Occupational Chemicals (heavy metal, organic solvent, etc.)	☐
15. Radiation	☐
16. Tuberculosis	☐
17. Other ____________	☐
SUBSTANCE USE	
18. Tobacco / alcohol / drugs (list amount per day)	☐

HEALTH HISTORY SUMMARY

HOSPITAL - Family Practice

Patient Name: ____________________
MR #: ____________________

PHYSICAL ASSESSMENT

CARDIOVASCULAR

	Normal	Abnormal
19. Skin	☐	☐
20. Neurologic	☐	☐
21. Extremities	☐	☐
22. HEENT / Fundi	☐	☐
23. Mouth / Teeth	☐	☐
24. Neck / Thyroid	☐	☐
25. Breast / Nipples	☐	☐
26. Cardiovascular	☐	☐
27. Respiratory	☐	☐
28. Abdomen	☐	☐
29. Gastrointestinal	☐	☐
30. Urinary	☐	☐
31. Other ____________________	☐	☐
32. Other ____________________	☐	☐

Check and detail POSITIVE FINDINGS below.
Use reference numbers.

Height	Weight	Pregravid Weight	B.P.	Pulse

PELVIC EXAMINATION

	Normal	Abnormal
33. Vulva	☐	☐
34. Vagina	☐	☐
35. Cervix	☐	☐
36. Uterus Size: _______ wks	☐	☐
37. Adnexa	☐	☐
38. Rectum	☐	☐

39. Measurements

DC (11>cm): __________________

Interspinous (>9cm): ______________

Sacrum: _____________________

Arch (>90º): ___________________

☐ Adequate ☐ Inadequate
☐ Borderline

40. Pelvic Type

☐ Gynecoid ☐ Anthropoid
☐ Android ☐ Platypelloid

EXAMINED BY:	DATE EXAMINED:

HEALTH HISTORY SUMMARY

HOSPITAL - Family Practice

Patient Name: ______________________

MR #: ______________________

G	T	Pt	A	L

LMP: __________ EDC: __________ EDC: __________

Age: __________ DOB: __________ Initial Weight: __________ Pre-Conceptual BP: __________

Date	GA	BP	Wgt	Tot Gain	FH	FHR	Urine Pro/Glu	Pos	Edema	DTRs	FM	Pain Ctx	Vag Disch	N / V	H / A	Rtn Visit	See Notes	MD Initial

WHITE COPY = OB Record **YELLOW COPY** = Postpartum Record

LEGEND

FH = fundal height

FHR = fetal heart rate

FM = fetal movement

Pos = position of baby

N/V = nausea -or- vomiting

H/A = headache

HEALTH HISTORY SUMMARY

HOSPITAL - Family Practice

Patient Name:

MR #:

INITIAL LABS	DATE	RESULT	REVIEWED	COMMENTS / ADDITIONAL LAB
Blood Type / Rh		A B AB O + / -		
Antibody Screen		+ / -		
Hct / Hgb / Platelet		_____ % _____ gm / dl / _____		
Rubella		Immune / Non - Immune		
RPR		+ / -		
HB S AG		+ / -		
Pap Smear		+ / -		
GC / Chlamydia		+ / - || + / -		
Urine Culture / Urinalysis				
Sickle Cell Prep / Hb Elec		AA AS SS AC SC AF		Screen Neg / Pos
HIV		+ / -		Pt Refused
PPD		+ / -		CXR:
15 - 20 WEEK LABS				
MSAFP				AFP Refused ____/____/____ Pt Initials:
DSTT				
24 - 28 WEEK LABS				
HCT / HGB || Plt		_____ % _____ gm / dl || _____		
Diabetes Screen		1 Hour:		
GTT (if screen abnormal)		___ FBS ___1 Hr ___2 Hr ___3 Hr		
Rh Neg Antibody Screen		+ / -		RhG given (28 wks) Signature:
UA / Urine C&S				
34 - 36 WEEK LABS				
RPR		+ / -		
GC / Chlamydia		+ / - || + / -		
Group Beta Strep				
HCT / HGB || Plt		_____ % _____ gm / dl || _____		
ULTRASOUNDS				
OTHER LABS				
Amnio / CVS				

PREGNANCY PLANNING SHEET

HOSPITAL - Family Practice

Physician:

Name: EDC:

DATE	PROBLEM LIST	PATIENT EDUCATION PLAN	INITIAL
		1st TRIMESTER	
		Orient to Family Practice	
		Warning Signs of Pregnancy	
		Diet Counseling	
		Domestic Violence	
		Breastfeeding Info	
		Drugs / Smoking / Etoh	
		2nd TRIMESTER	
		Exercises	
		Preterm Labor Education	
		Breastfeeding Info	
		Prenatal Classes	
		3rd TRIMESTER	
		Labor Instructions	
		Car Safety Seat Information	
		Breast Feeding Info	
		Tour of L & D	
		Prep for Newborn (crib, clothes)	
		Fetal Activity Monitoring	
		Discomfort / Relief Measures	
		Fertility Awareness	
		REFERRALS	
		WIC	
		Social Services	
		OB	

WHITE COPY = OB Record **YELLOW COPY** = Postpartum Record