West County Women's Healthcare Date: _____/_____/_____
Who is Your Regular Physician in the office: (Please Circle) McDonald Murphy Wallace-NP

Name: _____ DOB: ___/___/____ Occupation: _____
Emergency Contact: _____Phone: _____Partner/Spouse: _____

Menstrual History

LMP: ___/____/_____ Definite/Approximate Regular/Irregular Duration: _____ Frequency:_____
Last Pap Smear:_____ Results: Normal/ Abnormal First+ pregnancy test:____/____/_____

Past Pregnancies (Please List All)

Date	Weeks	Weight	Sex	Delivery Type	Anesthesia	Location	Comments/Complications

Past Medical History (Please Circle)

Allergies (Medication)	Anemia	Anxiety	Asthma
Auto Immune Disorder	Blood Clot/Bleeding Disorder	Blood Transfusion	Breast Disorder
Cancer	COPD	Depression	Diabetes
Drug/Alcohol Problem	Epilepsy	Gallbladder Disorder	Glaucoma
Headaches/Migraines	Hepatitis/Liver Disorder	Herpes	Hyperlipidemia
Hypertension	Infertility	Kidney Disorder/Stones	Mitral Valve Prolapse
MRSA	Osteopenia/Osteoporosis	Pelvic Infection	Pneumonia
Rheumatic Fever	Seizures	Sickle Cell Trait	Sleep Apnea
STI's	Stomach/Bowel Disorder	Stroke	TB
Thyroid Disorder	Trauma/Domestic Violence	UTI	Other:_____

Medication:_____

Allergies:_____

Surgeries:_____

Family History:_____

Do you Smoke? Y/N Do you drink? Y/N Do you use drugs? Y/N

Flu? Y/N Date:_____ COVID-19 Vaccine? Y/N if yes, when:_____ Booster Y/N

Birth Plan

Religious/Culture considerations:_____
Do you own an outside cat? Y/N
Do you plan to breast feed? Y/N
WIC Program? Y/N
Do you plan for tubal sterilization after delivery? Y/N
Would you like an epidural for delivery? Y/N
Desired delivery Method: Vaginal/ Cesarean Section/ VBAC
Desired delivery location:_____

Family History (Self or Father of baby) (Please Circle)

Thalassemia (Italian, Greek, Mediterranean, or Asian background)	Muscular Dystrophy
Neural Tube Defect (Myelomeningocele, Spina Bifida and Anencephaly)	Cystic Fibrosis
Congenital Heart Defect	Mental Disability (Autism Spectrum)
Down Syndrome	Maternal Metabolic Disorder (Insulin dependent diabetes or PKU)
Tay-Sachs (Jewish, Cajun, French-Canadian)	Recurrent pregnancy loss or still birth
Sickle Cell trait or disease	Birth Defects not listed:_____
Hemophilia	Other inherited genetic disorder:_____
	Other Chromosomal disorder:_____

Review of Systems (Please Circle)

General:
Weight Changes >10 lbs
Fever
Fatigue
Headache

Skin:
Rash/Sores
Mole Changes

Head and Neck:
Visual Changes (Not glasses)
Blurred Vision
Double Vision
Trouble hearing
Sinus Problems
Sore Throat

Musculoskeletal:
Joint pain
Muscle Weakness
Muscle Pain

Respiratory/ Lungs:
Shortness of Breath
Wheezing
Cough
Sleep Apnea

Neuro:
Numbness or Tingling
Dizziness
Seizures

Cardiovascular:
Chest pain
Difficulty breathing
Irregular heartbeat
Swelling

Endocrine:
Changes in hair/hair loss
Heat/cold Intolerance
Frequent Sweats/ Hot flashes
Excessive thirst

Allergic/Immunologic:
Hay Fever
Seasonal Allergies
Medications

Gastrointestinal:
Nausea/ Vomiting
Frequent heart burn/Acid
Abdominal Pain
Diarrhea (Frequent)
Constipation

Psych/Social:
High Anxiety/ Stress
Marital/ Relationship Problems
Depression mood/crying
Thoughts of Suicide
Forgetfulness/ Confusion

Hematologic/Lymphatic:
Swollen glands
Bruise/Bleed easily

Breast:
Nipple Discharge
Lumps
Skin Changes

Genitourinary/Women:
Pelvic Pain
Frequent Urination
Urine Leakage
Urine Retention
Burning with Urination
Vaginal Discharge
Vaginal Dryness
Abnormal bleeding
Menstrual Problems
Menopause
Infertility
Painful Periods
Painful Intercourse
Decreased Sexual Desire