



Women's Health For Life, Inc.

1005 Bellefontaine Ave., Suite 175
 Lima, OH 45804
 Phone (419) 227-2727
 Fax (419) 227-2737
 www.womenshealthforlife.com

770 West High Street, Suite 400
 Lima, OH 45801

OBSTETRICAL INFORMATION SHEET

Name		Age	Today's Date / /	
Date of Birth / /	Marital Status		Occupation	
Last Grade Completed	Family Practitioner	Insurance		
Date of Last Menstrual Period / /	How often are periods & days long?	Was pregnancy planned? Yes / No	Were you on birth control? Yes / No	

PAST PREGNANCIES

Date	Weeks	Length of Labor	Weight	Delivery Type	Where Delivered	Complications
/ /						
/ /						
/ /						
/ /						
/ /						

PAST MEDICAL HISTORY

	Yes	No		Yes	No
Sugar Diabetes			Infertility		
High Blood Pressure			Blood Transfusions		
Heart Problems			Mother Exposed to DES		
Heart Valve Problems			Rh Sensitization (Rhogam)		
Kidney Disease or Infections			Tuberculosis		
Neurologic/Seizures			Lung Problems – Asthma		
Depression/Mental Problems			Anesthetic Complications		
Hepatitis/Liver Disease			History of an Abnormal Pap		
Leg Vein Problems			Uterine Abnormality		
Thyroid Problems			Major Accident		

Have you, the baby's father or anyone in either family had:
 Thalassemia, neural tube defects, downs syndrome, tay-sachs disease, sickle cell, hemophilia, muscular dystrophy, cystic fibrosis, huntington's chorea, mental retardation, inherited chromosomal defects, or babies born with birth defects? If so indicate whom.

Do you or your partner have genital herpes?

Have you had a rash or illness since your last menstrual period?

Have you ever had a sexually transmitted disease (gonorrhea, chlamydia, condyloma, trichomonas or syphilis)?

Details of yes answers:



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SURGICAL HISTORY

Year	Operation	City	Surgeon	Complicaitons
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Current Medications:

Allergies & Reactions:

Cigarette Smoking:

Alcohol Consumption:

Drug or Marijuana Usage:

FAMILY MEDICAL HISTORY

Father

Mother

Siblings

Children

Grandparents

Aunts/Uncles

Cousins

CURRENT MEDICAL HISTORY

Please circle if you have any of the following:

Weight changes, appetite changes, unusual weakness, bleeding, chills, fevers, recent accidents or infections. Vision changes, hearing changes, bloody noses, unusual sneezing, sore throat, swallowing difficulties, ear pain or face pain. Neck pain, swelling or stiffness. Cough, difficulty breathing or coughing up blood. Chest pain or chest fluttering. Abdominal pain, sickness to stomach, throwing up, diarrhea, constipation or problems with stools. Difficulty with urination. Joint stiffness, back pain, muscle cramps. Rash, skin lesions, easy bruising or itching. Memory loss, dizziness, double vision, clumsiness or headaches

Other issues to bring to the attention of our staff:

THANK YOU

Signature

Parent or Guardian Signature (if Minor)

Date

Witness

NUTRITION QUESTIONNAIRE

Name _____

Date: _____ Height: _____ Weight Pre-pregnancy: _____ Today: _____ BMI: _____ Wt. Gain: _____

EATING BEHAVIOR

1) Are you frequently bothered by any of the following?

(Circle all that apply)

Nausea Vomiting Heartburn Constipation

- | | | |
|---|----|-----|
| 2) Do you skip meals at least three times a week? | No | Yes |
| 3) Do you try to limit the amount or kind of food you eat to control your weight? | No | Yes |
| 4) Are you on a special diet now? | No | Yes |
| 5) Do you avoid any foods for health or religious reasons? | No | Yes |

FOOD RESOURCES

- | | | |
|--|----|-----|
| 6) Do you have a working stove? | No | Yes |
| 7) Do you have a working refrigerator? | No | Yes |
| 8) Do you sometimes run out of food before you are able to buy more? | No | Yes |
| 9) Can you afford to eat the way you should? | No | Yes |
| 10) Are you receiving any food assistance now? | No | Yes |
- (Circle all that apply)
- | | | | |
|-------------|--------------------------|--------------|--|
| Food stamps | School breakfast | School lunch | |
| WIC | Donated food/commodities | CSFP | |
| Food pantry | Soup kitchen | Food bank | |
- | | | |
|--|----|-----|
| 11) Do you feel you need help in obtaining food? | No | Yes |
|--|----|-----|

FOOD AND DRINK:

- 12) Which of these did you drink yesterday?
(Circle and list servings of all that apply)
- | | | | |
|--------------|------------------|-----------------|--------------------|
| Soft Drink | Coffee | Tea | |
| Orange Juice | Grapefruit Juice | Fruit drink | |
| Milk | Kool-Aid | Water | |
| Beer | Wine | Alcoholic Drink | Other (List) _____ |
- 13) Which of these foods did you eat yesterday?
(Circle and list servings of each)
- | | | | |
|--------------------|------------------|---------------------|--|
| Cheese | Pizza | Macaroni and Cheese | |
| Yogurt | Cereal with Milk | Tacos with Cheese | |
| Enchilada | Lasagna | Cheeseburger | |
| Other (List) _____ | | | |
- | | | | |
|----------|----------------|----------------|------------------------|
| Corn | Potatoes | Sweet Potatoes | Green Salad |
| Carrots | Collard Greens | Spinach | Turnip Greens |
| Broccoli | Green Beans | Green Peas | Other Vegetables _____ |
- | | | | |
|--------|---------|---------|-------------------|
| Apples | Bananas | Berries | Grapefruit |
| Melon | Oranges | Peaches | Other Fruit _____ |
- | | | | |
|------|-------|---------------|-------------|
| Meat | Fish | Chicken | Eggs |
| Nuts | Seeds | Peanut Butter | Dried Beans |
- | | | | |
|-----------|--------------|-------------------------|---------|
| Cold Cuts | Hot Dog | Bacon | Sausage |
| Cake | Cookies | Doughnut | Pastry |
| Chips | French Fries | Other Fried Foods _____ | |
- | | | | |
|---|-----------|-----------|--------|
| Bread | Rolls | Rice | Cereal |
| Noodles | Spaghetti | Tortillas | |
| Were any of these whole grain? No Yes | | | |

- | | | |
|---|----|-----|
| 14) Is the way you ate yesterday the way you usually eat? | No | Yes |
| 15) Do you exercise for at least 20 minutes three times a week? | No | Yes |
- What type of exercise do you enjoy? _____



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GYNECOLOGY INFORMATION SHEET

Name				Age		Today's Date / /		
Why did you make this appointment?								
Family Physician			Marital Status M S D W			Insurance		
MEDICAL HISTORY				PREGNANCIES				
Have you ever had:		Yes	No	No.	Year	Months Pregnant	Type of Delivery	Problems
Heart disease				1.				
Lung disease				2.				
Kidney/Bladder disease				3.				
Seizure disorder				4.				
High blood pressure				5.				
Hyperlipidemia				Last Mammogram:		/ /	Normal? Yes / No	
Diabetes				Last Dexa Scan:		/ /	Normal? Yes / No	
Cancer				MENSTRUAL HISTORY				
Pelvic disease				Age periods started?			Regular? Yes / No	
Venereal disease				How often are your periods? Every			days.	
Tuberculosis				How long? days, from start to stop.				
Liver disease				Number of pads or tampons used each day?				
Blood disease				Pain with periods? Yes / No				
Mental illness				Spotting after intercourse? Yes / No				
Exposure to DES				Age of first sexual encounter?				
Drug dependency				Number of partners?				
Reaction to anesthetics				Are you using birth control? Yes / No				
Sexual abuse				Method?			Problems? Yes / No	
SURGICAL HISTORY				First day of last menstrual period?				
Year	Operation	City	Surgeon	Do you perform self breast exams?				
				PRESENT MEDICAL HISTORY				
				Do you feel you have problems with:		Yes	No	
				Ear, eyes, nose, throat, neck				
				Weight or appetite changes, infections				
MEDICATIONS (Name & Dosage)				Breathing or heart problems				
				Abdominal pain, bowel changes				
				Skin problems, joint or muscle aches				
				Memory loss or headaches				
ALLERGIES (reaction)				Menstrual periods/female organs				
				Breasts				
FAMILY HEALTH PROBLEMS (cancer, etc)				Energy/depression/weight/sleeping				
Father		Mother		Urinary symptoms				
Siblings				Abnormal bleeding				
Children				Hot flashes				
Grandparents				Hair growth				
How much do you smoke?				Pelvic pain with intercourse/sex life				
How much alcohol do you drink?				Marital problems				
Do you use IV or illegal drugs?				Date of last pap smear: / /		Normal? Yes / No		