UnityPoint Clinic

UnityPoint Clinic OB/GYN – Ankeny: (515) 289-8554
UnityPoint Clinic OB/GYN – Clive: (515) 265-9888
UnityPoint Clinic OB/GYN – Lakeview: (515) 241-2201
UnityPoint Clinic OB/GYN – Methodist Plaza: (515) 241-4022
UnityPoint Clinic OB/GYN – Waukee: (515) 265-9888

Please complete this form and return at least 48 hours before your appointment. You can mail or fax back. The OB/GYN clinic fax numbers are listed above.

Appointment date: ______________ Name: ______________________________________ DOB: _____________ Age: _____

Phone number: _____________________ Pharmacy: ____

Father of baby:____Phone number:___________________________________

Emergency contact name and number: ____

Current Meds/strength/how often: ____

Allergies/Reaction: ____

Please circle yes or no to all conditions and list which family member.

***Your family history includes only your children, siblings, parents, and grandparents.**

	Do **you** have?	***Your** Family History	Who?
Diabetes Mellitus	YES or NO	YES or NO	
Heart Disease	YES or NO	YES or NO	
Kidney Disease	YES or NO	YES or NO	
Depression	YES or NO	YES or NO	
Hepatitis	YES or NO	YES or NO	
Trauma/Violence	YES or NO	YES or NO	
Allergies	YES or NO	YES or NO	
Complications to Anesthesia	YES or NO	YES or NO	
Infertility	YES or NO	YES or NO	
Cancer	YES or NO	YES or NO	
High Blood Pressure	YES or NO	YES or NO	
Autoimmune Disorder	YES or NO	YES or NO	
Seizures	YES or NO	YES or NO	
Postpartum Depression	YES or NO	YES or NO	
Thyroid Disease	YES or NO	YES or NO	
Blood Transfusion	YES or NO	YES or NO	
Asthma	YES or NO	YES or NO	
Breast Problems	YES or NO	YES or NO	
STD	YES or NO	YES or NO	
Clotting Disorder	YES or NO	YES or NO	
Other	YES or NO	YES or NO	

Surgical History

Have you had:	Yes	No	Comment and or Year
Appendectomy			
Cesarean Section (C-section)			
Colonoscopy			

Colposcopy			
D & C			
Essure			
Gallbladder removal			
LEEP			
Ovary Removal			
Tubal Ligation			
Other			

Social History:

Please record your information:	Prior to Pregnancy?	Type	How often and for how long?	Current Pregnancy?	Type	How often and for how long?
Alcohol	Yes/No			Yes/No		
Drugs	Yes/No			Yes/No		
Tobacco/Smoking	Yes/No			Yes/No		

Who lives with you? ____

Do you work outside of the home? Yes/No If yes, then where do you work? _________________________________

Circle one: married/single/separated/divorced/widowed Preferred language: English/Spanish/Other: __________

Race: Asian/American or African/Hispanic or Latina/Mixed race/White Highest level of education/schooling: _____

Do you have regular dental exams? Yes/No Do you have any issues with bleeding gums? Yes/No

Will you be over 35 at delivery of this baby? Yes/No

Pregnancies: Please include miscarriages, stillbirths, ectopic, abortions.

Name	Birthdate	Term or premature	Length of labor	Weight	Gender	Delivery type (vag/csection)	Anesthesia Yes/No	Living?	Complications
1.					M/F			Yes/No	
2.					M/F			Yes/No	
3.					M/F			Yes/No	
4.					M/F			Yes/No	
5.					M/F			Yes/No	
6.					M/F			Yes/No	

Please answer for yourself and the father of the baby.

Genetic History	Yes	No	Who
Thalassemia			
Neural tube defect/spina bifida			
Heart defect			
Down's Syndrome			
Tay Sachs			
Canavan Disease			
Familial Dysautonomia			
Sickle Cell Disease or trait			
Hemophilia or blood problems			
Muscular dystrophy			
Cystic Fibrosis			

Huntington's Chorea			
Intellectual Retardation			
Autism			
Fragile X			
PKU			
Other inherited disorder			

Infection History:

Have **you,** or the **father of the baby** had or been exposed to:	Yes	No
Tuberculosis		
Herpes		
Hepatitis B		
Hepatitis C		
Gonorrhea		
Chlamydia		
Genital Warts		
HIV/AIDS		
Syphilis		
Chicken pox or vaccine		

Since your last period, have you had:	Yes	No
fever		
rash		
headache		
Burning with urination		
vomiting		
Vaginal bleeding		

Have you had a pap smear? Yes/No If yes, was it normal: Yes/No

Dating:

When was the first day of your last period? _________________________________

Is this date (circle one) exact/estimate

Was your bleeding on time? Yes/No

Was the bleeding normal for you? Yes/No

How many days do you normally bleed? ______________ days

How far apart are your periods ______________________ days

Were you on birth controls within 3 months of your last period? Yes/No

Will you accept a blood transfusion if it is necessary? Yes/No