Joshua L. Weiss, MD Associated
Health Information Form

Name:_____ DOB:_____ Today's Date:_____
Occupation:_____ Spouse/Partner's Name:_____
First Day of Last Menstrual Period:_____ Estimated Due Date:_____

Referring Physician:_____
Indication for Consultation:_____

List any known drug allergies:_____ **Height** _____ **Pre Preg Weight**_____
List any medications you are currently taking:_____

Your ethnic background:_____ Baby's father's ethnic background:_____

Pregnancy History: (Please include all pregnancies: full term, preterm, miscarriages, terminations etc)

Year	Weeks at Delivery	Boy/Girl	Weight	Vaginal or Cesarean	Indication for Cesarean	Complications

	Yes	No		Yes	No
Will you be 35 years or older at delivery?			Medication exposure?		
Will your husband be 50 years or older at delivery?			Radiation exposure? (X-ray, CT scan, etc.)		
Was there donor egg or sperm used?			Fever or Rash this pregnancy?		

Medical History:

	Yes	No		Yes	No		Yes	No
Diabetes			Liver (eg. Hepatitis)			Ulcers		
Hypertension			Thyroid			Arthritis		
Heart Disease			Seizures/Epilepsy			HIV		
Asthma/Lung			Blood Clots (eg. DVT)			Blood Transfusions		
Kidney			Lupus			Trauma		
Depression			**Other:**					

Surgical History:

Year	Surgery	Indication

Gynecology History:
Age of first period:_____ Periods (circle all that apply): Regular / Irregular / Heavy / Other:_____

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	Yes	No		Yes	No
Infertility			Endometriosis		
Conceived by IVF / Assisted Procedure			Fibroids		
Prior Cervical Surgeries			Abnormal Pap Smear		
Cervical Insufficiency			History of Sexually Transmitted Disease		

Genetic Screening (Family History including patient, father or anyone in either family):

	Yes	No		Yes	No		Yes	No
Italian, Greek, Mediterranean or Asian Background (Thalassemia)			Tay-Sachs			Congenital Heart Malformation		
Sickle Cell Trait/Disease			Canavan Disease			Birth Defects		
Hemophilia			Cystic Fibrosis			Recurrent Pregnancy Loss		
Neural Tube Defect (spina bifida, anencephaly)			Muscular Dystrophy			Other?		
Down syndrome			Fragile X					
Chromosomal abnormality			Huntington's Chorea					
Mental Retardation/Autism			PKU					

Social History:

	Yes	No	
Tobacco			
Alcohol			
Illicit/Recreational Drugs			
Do you wear your seatbelt?			
Exercise			

Review of Systems: (If you have present symptoms mark YES, if none, leave blank)

1. Constitutional		**5. Respiratory**		**10. Psychological**	
Fevers		Wheezing		Depressed	
Chills		Frequent Cough		Anxious	
Sleep Difficulties		Shortness of Breath		Other	
2. Eyes		**6. Gastrointestinal**		**11. Endocrine**	
Double Vision		Nausea/Vomiting		Excessive Thirst	
Seeing Stars		Abdominal Pain		Heat/Cold Intolerance	
Vision Changes		**7. Genitourinary**		**12. Hematologic**	
3. Ear/Nose/Throat		Painful Urination		Clotting Problems	
Hearing Changes		Blood in Urine		Bruising	
Sore Throat		**8. Musculoskeletal**		**13. Neurological**	
Sinus Problems		Joint Pain		Numbness/Tingling	
4. Cardiovascular		Muscle Pain		Dizziness	
Chest Pain		Bone Pain		**14. Allergic**	
Irregular Heart Rate		**9. Integumentary**		Seasonal Allergies	
		Rashes/Moles/Lumps		**Other:**	

Completed by: ___ Patient ___ Office Nurse ___ Physician

Patient Signature:_____ Physician Signature:_____ Date Reviewed:_____