COPLEY

PATIENT HISTORY QUESTIONNAIRE - CONFIRMATION VISIT

Our goal is for you to be as healthy as possible. This is a detailed history form to get the big picture about your current health and your individual needs. Please complete and email/mail this questionnaire back prior to your first visit.

PATIENT INFORMATION

Patient name (last, first, M.I): _____Chosen Name: _____
Gender Identity: ☐Female ☐Male ☐Nonbinary ☐_____ Date of birth:_____ Age: _____
Sex assigned at birth: ☐Female ☐Male ☐Intersex Pronouns:☐she/her ☐he/him ☐they/them ☐_____
Ethnic group/race: _____
Are you: ☐Single ☐In a relationship ☐Married ☐Divorced ☐Widowed ☐Other: _____

Name of partner _____Age_____ Pronouns:☐she/her ☐he/him ☐they/them ☐_____
Is this the second biological parent of the baby?☐Yes ☐No ☐Unknown Ethnic group/race:_____
Occupation _____
Has your partner ever had genital herpes, HIV, viral hepatitis or other conditions that could affect this pregnancy?☐Yes ☐No

YOUR BODY BEFORE THIS PREGNANCY

At what age did you get your first period?_____
Is this a desired pregnancy?☐Yes ☐No If no, would you like to discuss options for termination or adoption? ☐Yes_____ ☐No
Birth control method in past year: ☐None ☐Pills: _____ ☐Condoms ☐Natural family planning ☐IUD_____
☐Ring ☐Patch ☐DepoProvera injection ☐Nexplanon ☐Other When did you stop using this method? _____
Have you used emergency contraception in the past year?☐Yes ☐ No If so, how many times? _____

First day of your last period: _____☐Exact (+/- one day)☐Approximate☐Unknown

- Was your period normal in number of days and flow? ☐Normal ☐Abnormal
- Were your periods every 25-32 days? ☐Yes ☐No - describe: _____

Date of conception, if known: _____ Date of Positive Pregnancy Test _____
Did you have fertility treatment for this pregnancy? ☐Yes ☐No

- If yes, please explain: _____
- ☐IUI (date) _____ ☐Embryo transfer date_____ ☐Age of embryo (3 or 5 days)
- Are you a surrogate or gestational carrier for this pregnancy? ☐Yes ☐No

Did you have 3 normal natural menstrual cycles in a row prior to conceiving? ☐Yes ☐No
Do you have any history of breast/chest surgeries? (implants/reduction) ☐Yes ☐No
Were you breastfeeding/chestfeeding during your last 3 menstrual cycles? ☐Yes ☐No

- If yes, are you breastfeeding/chestfeeding now? ☐Yes ☐No If no, date stopped _____

Are you planning to breastfeed/chestfeed after this pregnancy? ☐Yes ☐No ☐Undecided
Have you had breastfeeding/chestfeeding problems in the past? ☐Yes ☐No

- If yes, please explain _____

CURRENT SYMPTOMS List any concerns or problems that you have with your current pregnancy.

☐Breast/chest changes_____
☐Nausea and vomiting _____
☐Vaginal symptoms (bleeding, spotting, abnormal discharge)_____
☐Abdominal pain or cramping_____
☐Change in bowel habits (constipation, diarrhea) _____
☐Urinary symptoms (frequency, burning, pain with urination) _____
☐Fatigue _____
☐Other _____

ALLERGIES

Do you have any allergies to any medications or foods? Yes No If yes, please list and describe the reaction. ie: Penicillins - hives

Allergy	Reaction

CURRENT MEDICATIONS

Include prescribed, over-the-counter drugs, folic acid or vitamins, herbal remedies or supplements, inhalers

Name of medication	Strength/dose	Frequency taken	Reason for taking

PAST OBSTETRIC HISTORY

Total number of pregnancies (please list below)_____ Living children _____Full-term births _____ Premature births _____
Multiple births_____ Miscarriages _____ Terminations _____ Tubal pregnancies _____ Molar pregnancies _____

Previous Pregnancies (Include miscarriages, terminations, and/or ectopic/tubal pregnancies)										
Date	How many weeks did your pregnancy last?	How long was your labor? (hours)	Type of birth (vaginal, cesarean, forceps, vacuum)	Sex Assigned: M/F/ Other Baby Name	How much did your baby weigh?	Did you have preterm labor?	Did you or your baby experience any problems during labor or birth?	Were there any other pregnancy or procedural complications?	Did you use anesthesia? If so, what type? (eg: nitrous, narcotics, epidural, spinal)	Place of birth/ CNM/ OB

Have you had problems in your prior pregnancies not listed above?	Please explain:
☐ gestational diabetes ☐ pelvic floor problems or incontinence ☐ high blood pressure ☐ pelvic pain ☐ pre-eclampsia ☐ 3rd or 4th degree laceration ☐ postpartum hemorrhage or excessive bleeding after birth ☐ other	

PAST GYNECOLOGIC HISTORY

When was your last pap test? _____ Was it normal? ☐ Yes ☐ No
Have you ever had an abnormal pap test? ☐ Yes ☐ No
Have you completed vaccination for Hepatitis B? ☐ Yes ☐ No
Have you completed vaccination for HPV (Gardasil/Cervarix/other)? ☐ Yes ☐ No

Who do you have sex with? ☐ Partner(s) with a penis ☐ Partner(s) with a vagina ☐ _____
Do you use condoms? ☐ Yes ☐ No
How many partners do you currently have? _____ How many partners in the past 6 months? _____
Have you ever had any of the following infections?
☐ Chlamydia ☐ Genital herpes ☐ Genital warts ☐ Gonorrhea ☐ Syphilis ☐ HIV/AIDS ☐ HPV ☐ Pelvic inflammatory disease (PID)

Have you had past infertility workups or treatment? ☐ Yes ☐ No If yes, please describe: _____
Do you have a history of fibroids or abnormally shaped uterus? ☐ Yes ☐ No If yes, please describe: _____

Have you ever had a gynecological surgical procedure such as:

☐ Ectopic pregnancy or surgery on your fallopian tube
☐ LEEP procedure
☐ Cervical conization
☐ Cryosurgery (freezing) of the cervix
☐ Laser treatment
☐ Dilation/curettage (D&C)
☐ Hysteroscopy
☐ Cerclage
☐ Other/Date: _____
☐ None

Include other dates and details on above or any other gynecologic issues (incontinence, vulvodynia, vulva vestibulitis, other)

PAST MEDICAL HISTORY

☐ Hypertension (high blood pressure)
☐ Autoimmune disease (eg: lupus, rheumatoid arthritis, other)
☐ Epilepsy or seizures ☐ Migraine headaches
☐ Stroke ☐ Other neurologic problems
☐ Hepatitis B or C/ liver disease/yellow jaundice (circle any that apply)
☐ Thyroid problems or take thyroid medication
☐ Other endocrine problems
☐ History blood transfusions ☐ Anemia
☐ Excessive bleeding after surgery or dental work
☐ Asthma or other pulmonary issues
Have you had chicken pox (varicella)? ☐ Disease ☐ Vaccine
☐ Covid-19 vaccination(s); approx. date of most recent _____
☐ Heart problems
☐ Kidney disease, kidney infections
☐ Frequent UTIs or other urinary tract problems
☐ Depression/anxiety/ADHD/other psychiatric conditions (circle any that apply)
☐ Eating disorder (anorexia, bulimia, other)
☐ Major accidents or suffered trauma
☐ Blood clots in your veins/deep vein thrombosis/inflammation of the veins/phlebitis/pulmonary embolism (circle any that apply)
☐ Breast problems or surgeries not mentioned previously
☐ Diabetes (high blood sugar)
☐ Vitamin D deficiency
☐ None

If yes, please explain:

Do you have, or have you ever had, any of the following?

☐ Pernicious anemia ☐ Celiac disease ☐ MTHFR (methyltetrahydrofolate reductase) mutation
☐ Weight loss surgery ☐ Crohn's disease ☐ Family history of MTHFR mutation ☐ Factor V Leiden
☐ Irritable bowel syndrome ☐ Ulcerative colitis ☐ Ulcers, acid reflux, other GI issues ☐ None

If yes, please explain: _____

Surgical procedures, other than obstetrical or gynecologic, give reason and date if yes: ☐Yes ☐No

- If yes, please explain: _____

A hospital stay for a non-surgical reason other than normal birth: ☐Yes ☐No

- If yes, please explain: _____

Have you had any complications from anesthesia? ☐Yes ☐No

- If yes, please explain: _____

Have you ever been exposed to tuberculosis? ☐Yes ☐No

- If yes, please explain: _____

Have you ever had any other infectious disease (including Covid)? ☐Yes ☐No

- If yes, please explain: _____

GENETICS AND FAMILY HISTORY

Family History – Please list the family member who has had one of the conditions below and their age at diagnosis

- Asthma, blood clots (DVT), diabetes, heart disease, high blood pressure, thyroid disease
- Cancer: Breast, Colon, Ovarian, Pancreatic, Skin, Stomach, Uterine (not cervical cancer)
- Psychiatric conditions (anxiety, depression, bipolar, other)

Family Member	Condition/Age at Diagnosis

Genetic History - Please indicate if any of these conditions apply to your family or anyone in the family of the other biological parent.

NAME OF CONDITION	YES	NO	RELATIONSHIP OF AFFECTED PERSON TO YOU
Neural tube defect (open spine, spina bifida, anencephaly)			
Congenital heart disease or defect			
Down Syndrome (Trisomy 21)			
Hemophilia or other blood clotting disorders			
Cystic Fibrosis			
Any genetic muscle disorders like Muscular Dystrophy, Spinal Muscular Atrophy (SMA)			
Intellectual or mental disability			
Autism			
Fragile X syndrome			
Bone/skeletal defects			
Polycystic kidney disease			
Cleft lip/palate			
Other familial, genetic or chromosomal disorders			

Are you or the other biological parent of the baby of Ashkenazi Jewish ancestry? ☐Yes ☐No

- If yes, have you been screened for: ☐Tay-Sachs disease ☐Canavan disease ☐Familial dysautonomia
- If yes, who was screened and what were the results? _____

Are you or the other biological parent of the baby of African or African American ancestry? ☐Yes ☐No

- If yes, have either of you been screened for sickle cell trait or disease?
- If yes, who was screened and what were the results? _____

Are you or the other biological parent of the baby of Mediterranean or Asian ancestry? ☐Yes ☐No

- If yes, have either of you been screened for: ☐Thalassemia ☐Sickle cell disease or trait
- If yes, who was screened and what were the results? _____

Do you or the other biological parent have:

- ☐Insulin dependent diabetes, phenylketonuria (PKU), congenital adrenal hyperplasia (CAH) or any other metabolic disorder
- ☐A prior child with a birth defect or medical condition needing surgery not listed above
- ☐Three or more miscarriages or prior stillbirth
- ☐A child that died shortly after birth or during childhood

If yes, please explain: _____

Do you have a parent or sibling who had pre-eclampsia? ☐Yes ☐No

Were you born at a low birth weight (less than 6 pounds)? ☐Yes ☐No

SOCIAL HISTORY

What is your profession/occupation? _____

What are your hobbies/activities? _____

How often do you exercise? What kind of exercise do you do?_____

Do you eat at least 5 servings of fruits/veggies per day? ☐Yes ☐No What is your favorite vegetable? _____

Do you avoid certain foods groups (gluten, red meat, etc) _____

Do you drink caffeine (soda, tea, coffee)? ☐Yes ☐No If yes, type and number of cups per day_____

Do you have any religious or cultural preferences that may impact your care? ☐Yes ☐No

If yes, please describe _____

Are you part of the LGBTQ+ community? _____

Would you agree to a have a blood transfusion in order to save your life or the life of your baby? ☐Yes ☐No

Who do you currently live with? _____

Do you have cats at home? ☐Yes ☐No If yes, do you change the litterbox? ☐Yes ☐No

Do you have lead based paint at home (usually in homes built before 1978)? ☐Yes ☐No ☐Unsure

Does anyone in your home smoke/vape? ☐Yes ☐No If yes, what substance(s)? _____

Do you wear your seatbelt every time you drive or ride in a vehicle? ☐Yes ☐No

Have you traveled outside of the country in the past 6 months? ☐Yes ☐No If yes, where? _____

Have you experienced a death or other trauma that may affect this pregnancy? ☐Yes ☐No

- Comments: _____

Are there other medical or personal concerns that we have not asked you about which you feel might be of importance to this pregnancy?

☐Yes ☐No If yes, please explain: _____