



OBSTETRIC MEDICAL HISTORY

Name:

LAST

FIRST

MIDDLE

Date Form Completed: - -

If you are uncomfortable answering any questions, leave them blank; you can discuss them with your doctor or nurse.

Personal Health History

1. ☐ Yes ☐ No

Have you ever had an allergic reaction to a medication or vaccine component?

If yes, please list: _____

Any other allergies or reactions? _____

2.

Please mark any condition that you have or have had in the past:

☐ Epilepsy

☐ Anemia

☐ Recurrent Urinary
Tract Infections

☐ Sexually Transmitted
Infections

☐ Headaches

☐ von Willebrand disease or
other bleeding disorders

☐ Gestational Diabetes

☐ HIV/AIDS

☐ Thyroid Disorder

☐ Blood Clotting Disorder
(eg, Phlebitis/Thrombophilia)

☐ Diabetes (Type 1 or Type 2)

☐ Frequent Infections

☐ Breast Disease

☐ Blood Transfusion

☐ Arthritis or Lupus

☐ Psychiatric Illness

☐ Asthma

☐ Gastrointestinal Illness

☐ Skin Disorders

☐ Depression/Postpartum
Depression

☐ Tuberculosis

☐ Hepatitis

☐ Prior Preterm Birth

☐ Eating Disorder

☐ Heart Disease

☐ High Blood Pressure

☐ Kidney Disease

☐ Group B Streptococcus In
Prior Pregnancy

☐ Other: _____

☐ Cancer

☐ Herpes

Describe, if needed: _____

3.

Please indicate any surgery or hospitalization that you have had and the date:

4.

Please describe any health problems or symptoms that you are having at this time:

5. ☐ Yes ☐ No

Do you or any family member have a history of problems with anesthesia?

If yes, please describe: _____

6. ☐ Yes ☐ No

Do you have any objections to any form of medical treatment (eg, blood transfusion)?

If yes, please describe: _____

Exposures Affecting Health

1. ☐ Yes ☐ No	Do you currently or have you in the past year smoked, chewed, used any type of nicotine delivery system (ENDS), or vaped? If yes, how many packs per day? _____ If former smoker/user, when did you quit? _____
2. ☐ Yes ☐ No	Do you drink alcoholic beverages now or did you before you became pregnant? If yes, please indicate number of drinks per week: _____ What type of drinks? _____
3.	Please list any medications taken since your last period, including prescriptions, over-the-counter drugs, multivitamins, other supplements, and any herbal medicines: _____ _____
4. ☐ Yes ☐ No	Have you used any street drugs since your last menstrual period (e.g., cocaine, marijuana, opioids)? If yes, please indicate number of uses per week: _____ What type of drugs? _____
5. ☐ Yes ☐ No	Do you have any reason to believe you or your partner may have been exposed to HIV/AIDS? This may include a history of blood transfusion, IV drug use, sex with gay or bisexual men, or sex with someone who has used IV drugs?
6. ☐ Yes ☐ No	Have you been exposed to chemicals (e.g., pesticides, lead, hazardous material/agents) or radiation (e.g., X-rays) since you became pregnant? If yes, please describe: _____
7. ☐ Yes ☐ No	Are you on a restricted diet? If yes, please describe: _____

Gynecologic Health History

1.	When was your last Pap test? _____ ☐ Yes ☐ No Have you received all three doses of the HPV vaccine? ☐ Yes ☐ No Have you ever had an abnormal pap test? If yes, when and how were you treated? _____ _____ What was the diagnosis? _____ ☐ Yes ☐ No Have you ever had HPV?
2. ☐ Yes ☐ No	Have you ever had ☐ Gonorrhea ☐ Chlamydia ☐ Pelvic Inflammatory Disease If yes, when, how, and where were you treated? _____
3. ☐ Yes ☐ No	Have you ever had herpes? If yes, where do you have outbreaks? _____ If yes, how often do you have outbreaks? _____ ☐ Yes ☐ No Have you ever had syphilis? If yes, how, when, and where were you treated? _____
4. ☐ Yes ☐ No	Have you ever used an intrauterine device (IUD) for contraception? If yes, please indicate when: _____ ☐ Yes ☐ No Did you have any problem with the IUD? If yes, please describe: _____
5. ☐ Yes ☐ No	Have you been treated for infertility? If yes, please describe when and treatment received: _____ _____
6. ☐ Yes ☐ No	Do you have any other concerns related to your past health history? If yes, please list: _____ _____

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Family History & Genetic Screening

1.	What is your ethnicity? _____	What is the ethnicity of the baby's father? _____
2.	☐ Yes ☐ No Have you or has the baby's father had a child born with a birth defect? If yes, please describe: _____	
3.	☐ Yes ☐ No Did either you or the baby's father have a birth defect? If yes, please describe: _____	
4.	Please describe any special needs that have occurred in children of your family or the baby's father's family (eg, cognitive impairment/intellectual disability, birth defects, early infant death, deformities, or inherited diseases, such as hemophilia, muscular dystrophy, or cystic fibrosis): 	
	How is this child/person related to you? _____	
5.	☐ Yes ☐ No Do you or does the baby's father have a history of pregnancy losses (miscarriages or stillbirths)? If yes, have either of you had genetic counseling? ☐ Yes ☐ No If yes, have either of you had chromosomal testing? ☐ Yes ☐ No Where and what were the results? _____	
6.	Some genetic problems occur more in couples with certain racial or ancestral backgrounds. Please check if you are, or the baby's father is, of one of these backgrounds: ☐ Yes ☐ No Eastern European Jewish (Ashkenazi) Ancestry If yes, have you had Tay Sachs screening tests? ☐ Yes ☐ No If yes, have you had a Canavan screening test? ☐ Yes ☐ No If yes, have you had familial dysautonomia screening? ☐ Yes ☐ No Date: ____/____/____ Result: _____ ☐ Yes ☐ No African American If yes, have you had sickle cell screening? ☐ Yes ☐ No Date: ____/____/____ Result: _____ ☐ Yes ☐ No Mediterranean Ancestry or Southeast Asian Ancestry If yes, have you had screening for inherited forms of anemia such as Thalassemia? ☐ Yes ☐ No ☐ Yes ☐ No French Canadian or Cajun Ancestry If yes, have you had Tay-Sachs screening tests? ☐ Yes ☐ No	
7.	☐ Yes ☐ No Have you had cystic fibrosis screening?	
8.	☐ Yes ☐ No Have you had any other genetic carrier screening, such as an expanded carrier screening? Screening: _____ Date: ____/____/____ Result: _____	
9.	Please list any other concerns you have about birth defects or inherited disorders: 	
10.	☐ Yes ☐ No Do you want a test that will tell you about your risk to have a baby with Down syndrome?	
11.	☐ Yes ☐ No Is the father 45 years or older?	

Psychosocial Screening*	
1. ☐ Yes ☐ No	Do you have any problems (e.g., job, transportation) that prevent you from keeping your health care appointments?
2. ☐ Yes ☐ No	Do you feel unsafe where you live?
3. ☐ Yes ☐ No	Are you exposed to second-hand smoke? ☐ Yes ☐ No In the past 2 months, have you used any form of tobacco, including smoked, chewed, any type of nicotine delivery system (ENDS), and vaped?
4. ☐ Yes ☐ No	In the past 2 months, have you used drugs or alcohol (including beer, wine, or mixed drinks)?
5. ☐ Yes ☐ No	In the past year, have you been threatened, hit, slapped, or kicked by anyone you know?
6. ☐ Yes ☐ No	Has anyone forced you to perform any sexual act that you did not want to do?
7. On a 1-5 scale, how do you rate your current stress level? Low	1 2 3 4 5 High
8. How many times have you moved in the past 12 months?	_____
9. If you could change the timing of this pregnancy, would you want it	☐ earlier ☐ later ☐ not at all / NA

PATIENT SIGNATURE

PRINT NAME _____

DATE _____

[illegible]

Tricefy™ your ultrasound at



- ☐ I want my ultrasound images delivered digitally as an email or text.

Email Address: _____

Mobile Phone Number: (_____)_____

- ☐ I authorize the sending of images during my pregnancy.
- ☐ I have read, understand, and agree to this disclaimer.

Name: _____

Signature: _____ Date: _____

Patient Disclaimer and Authorization

Tricefy™ is a communication service licensed to your provider. This Disclaimer and Authorization Agreement set forth the terms and conditions under which you, the undersigned patient authorize Your Provider to transmit your ultrasound examination through Trice Imaging, Inc. to a mobile phone number and email address of your choice. This Agreement will become effective on the date of your signature and will terminate after all images throughout your current pregnancy are sent to you.

After you complete and sign this Agreement, a mobile telephone number or email address you designate will be entered into our ultrasound system and re-verified with you. When your ultrasound screening is complete, in accordance with your provider's policies and procedures, the sonographer will trigger the ultrasound machine to send an encrypted copy of your examination to the Tricefy™ server. The server will reformat and encrypt the file and provide access to the examination through your mobile phone number and a text or email. The physician will have the discretion to determine whether your ultrasound screening is complete and whether to transmit your images to Tricefy™. The Physician has the right to refuse to transmit or to delay the transmission of your images. Both the text and email message will contain secure links and instructions on how to access the images. Images and videos can be accessed and downloaded to your mobile phone and computer.

You agree to pay all costs for the services if applicable. Transmission of the images through Trice Imaging, Inc. is not a medical service. The transmitted images are not considered diagnostic medical images and are not a part of your medical record; they are not to be used for your health care, diagnosis or treatment. If you want to see your medical records, you need to contact your provider, who is responsible for maintaining your medical records. Neither your provider, nor Trice Imaging, Inc. is responsible for the security of the transmitted images once the text and email recipients you have designated download the images. By directing your provider to transmit the images to an email address and telephone number that you specify, you authorize your provider and Trice Imaging, Inc. to provide the images to the person who owns or uses the email address and telephone number and any persons who may have access to the telephone number and email address. We would recommend immediate download of any images, as the link to the images will only be active for a maximum of 90 days. Any transmission of additional images will be considered new services, the cost for which the patient is obligated to pay, if applicable. Trice Imaging Inc. will not store the images on its server for you.

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