SINAI HOSPITAL
a LifeBridge Health center

PRECONCEPTIONAL
HEALTH ASSESSMENT

NAME:______________________ SS#: ______________ DATE: ____________

DATE OF BIRTH: ______________ AGE: ________ MARITAL STATUS: __________

HOME ADDRESS: ______________________________ RACE: __________

CITY, STATE, ZIP CODE: __________________________ RELIGION:__________

OCCUPATION: ____

WORK PHONE: ____________________ HOME PHONE: ________________

EDUCATION: ____

FAMILY PHYSICIAN OR REFERRING PHYSICIAN: ______________________

ADDRESS: ________________________ PHONE: ________________

REASON FOR CONSULTATION: ______________________________

History of Pregnancies: Please complete information about all of your pregnancies (Begin with most recent)
(If more room is needed, please use page 3)

No.	Month/Year	Weight at birth	Sex	Gestational Age	Delivery Type	Complications – Describe if Any

History of: Preterm Labor ____ Premature Rupture of Membranes ____ Multiple Births ____ Ectopic ____Congenital Anomalies ____ Abnormal Pregnancy Molar ____

Total number or pregnancies: _____ Term _____ Premature Birth _____ Number of Miscarriages _____Number of abortions _____ Number of living children _____

Hospitalizations/Surgeries: List all past surgeries (operations) and hospital stays with dates, if known. Please include most recent hospitalization.

- ☐ Tonsillectomy
- ☐ Hemorrhoidectomy
- ☐ Cholecystectomy
- ☐ Hernia
- ☐ D&C
- ☐ Laparoscopy
- ☐ Others
- ☐ None

Hospitalizations	Reason	Date

Any anesthesia complications:______________________________

ALLERGIES: Please list any allergies you have to drugs, food, or the environment and type of reaction:

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Allergy to Latex? ____ Yes ____ No If yes, describe: ______________________

Allergy to Betadine? ____ Yes ____ No If yes, describe: ______________________

MEDICATIONS: List all medications you are taking (Prescription & Over-the-Counter)

Name of Medication	Dosage	How Often Taken	Have you ever received blood transfusions or blood products? ____ Yes ____ No If yes: list number of units and dates: ______________

In order that we may address your specific interests and concerns, please complete the following questionnaire:

> SOCIAL HISTORY

Do you:

- □ Drink beer, wine or hard liquor?
- □ Smoke cigarettes or use any other tobacco products
- □ Use marijuana, cocaine or any recreational drugs
- □ Use lead or chemicals at home or at work?
  If yes, list the specific chemicals if you know them:
- □ Work with radiation?
- □ Participate in an exercise program?

Are you:

- □ 34 years of age or older?

> NUTRITION HISTORY

Do you:

- □ Practice vegetarianism?
- □ Eat unusual substance, such as laundry starch or clay?
- □ Have a history of bulimia or anorexia?
- □ Eat a special diet? If yes, describe:
  ____
- □ Supplement with vitamins: If yes, list vitamins and dosages:
  ____
- □ Take medications, including oral contraceptives?
- □ Have an intolerance for milk?

> MEDICAL HISTORY

Do you now have or have you ever had:

- □ Diabetes mellitus?
- □ Thyroid disease?
- □ Phenylketonuria (PKU)?
- □ Asthma?
- □ Heart disease?
- □ High blood pressure?
- □ Deep venous thrombosis (blood clots)?
- □ Kidney disease?
- □ Systemic lupus erythematosus (SLE)?
- □ Epilepsy?
- □ Sickle cell disease?
- □ Cancer
- □ Chicken Pox?
- □ Other health problems that require medical or surgical care?
  If yes, describe: ______________________________

> INFECTIOUS DISEASE HISTORY

Do you or your partner have a history of:

- □ Recurrent genital infections?
- □ Herpes simplex?
- □ Chlamydia infection?
- □ Human papillomarvirus (genital warts)?
- □ Gonerrhea?
- □ Syphilis?
- □ Viral hepatitis?
- □ Human immunodeficiency virus (HIV)?
- □ High-risk behaviors, including use of intravenous street drugs, intimate bisexual/homosexual contact or multiple sexual partners?
- □ Blood transfusions?
- □ Occupational exposure to the blood or bodily secretions of others?

> REPRODUCTIVE HISTORY

Do you:

- □ Use contraception

Do you have a history of:

- □ Uterine or cervical abnormalities?
- □ Two or m ore pregnancies that ended between 14 and 28 weeks of gestation?
- □ One or more fetal deaths?
- □ One or more infants who weighed less than 5 ½ pounds at birth?
- □ One or more infants who were admitted to a neonatal intensive care unit?
- □ One or more infants with a birth defect?

> FAMILY HISTORY

Do you, your partner, or members of either of your families, including offspring, have:

- □ Hemophilia?
- □ Thalassemia?
- □ Tay-Sachs disease?
- □ Sickle cell disease or trait?
- □ Phenylketonuria (PKU)?
- □ Cystic fibrosis?
- □ Birth defects?
- □ Mental retardation?
- □ Are you and your partner related outside of marriage (such as cousins)?
- □ Do you and your partner share the same ethnic or racial background, such as Ashkenazi Jew, Mediterranean or African American or African decent?

> IMMUNIZATIONS

Are you up to date with your vaccinations:

- □ Tetanus/Diphtheria booster (every 10 years)?
- □ Measles?
- □ Mumps?
- □ Rubella?
- □ Chicken Pox?
- □ Hepatitis B?

ADDITIONAL COMMENTS OR CONCERNS THAT YOU WOULD LIKE TO DISCUSS:

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______________________________________ ______________________________

Patient Signature Date

PHYSICIAN'S USE ONLY

- ☐ Folic Acid Supplementation
- ☐ Nutrition Counseling
- ☐ Vaccinations
- ☐ Prenatal Profile:
- ☐ HIV
- ☐ CF Testing

IMPRESSION:

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PLAN:

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______________________________________,M.D. ____________________

Physician Signature Date