Name/Nombre: ______________________________ Date of Birth/Fecha de Nacimiento: ______________________________

PAST MEDICAL HISTORY I HISTORIA MEDICA

(If **you personally** have EVER HAD or CURRENTLY HAVE any of the problems listed below, please circle YES and explain the situation in the comments section, otherwise please circle NO

(Por favor conteste todas las preguntas que siguen. Si su respuesta es "SI", de una explicacion abajo)

**HEALTH CONDITION**

| Condition | Response |
|---|---|
| 1. DIABETES / DIABETES | ☐ YES / SI ☐ No |
| 2. HIGH BLOOD PRESSURE / ALTA PRESION | ☐ YES / SI ☐ No |
| 3. HEART DISEASE OR PROBLEMS, RHEUMATIC FEVER, RHEUMATIC HEART DISEASE or MITRAL CALCE PROLAPSE<br>If yes, do you require antibiotics for dental procedures?<br>CUALQUIER ENFERMEDAD o PROBLEMA DEL CORAZON<br>Encaso que si, requiere antibioticos para trabajo dental? | ☐ YES / SI ☐ No |
| 4. IMMUNE SYSTEM DISORDER (lupus, rheumatoid arthritis)<br>DESORDEN DEL SYSTEMA INMUNE (lupus, artritis reumatoide) | ☐ YES / SI ☐ No |
| 5. BLADDER INFECTIONS or KIDNEY PROBLEMS (stones, infection)<br>INFECCIONES DE LA VEJIGA o PROBLEMAS DEL RINON | ☐ YES / SI ☐ No |
| 6. SEIZURE DISORDER (epilepsy) or NEUROLOGIC PROBLEMS<br>PROBLEMAS NEUROLOGICOS o DESORDEN EPILEPTICO | ☐ YES / SI ☐ No |
| 7. MENTAL HEALTH DISORDERS or PROBLEMS / DESORDENES o PROBLENAS MENTALES | ☐ YES / SI ☐ No |
| 8. DEPRESSION or POSTPARTUM DEPRESSION / DEPRESION o DEPRESION POSPARTOS | ☐ YES / SI ☐ No |
| 9. LIVER DISEASE or HEPATITIS (yellow jaundice) / ENFERMEDAD DEL IGADO o HEPATITIS | ☐ YES / SI ☐ No |
| 10. VARICOSE VEINS, PHLEBITIS or EMBOLISM (blood clots inside the vein)<br>VARICES, FLEBITIS o EMBOLIA | ☐ YES / SI ☐ No |
| 11. THYROID PROBLEMS / PROBLEMAS DE LA TIROIDEO | ☐ YES / SI ☐ No |
| 12. MAJOR TRAUMA or DOMESTIC VIOLENCE / TRAUMA MAYOR o VIOLENCIA DOMESTICA | ☐ YES / SI ☐ No |
| 13. BLOOD TRANSFUSION EVER / TRANSFUSION DE SANGRE | ☐ YES / SI ☐ No |
| 14. TOBACCO USE PAST or CURRENT / USO DE TABACCO PRESENTE o PASSADO<br>a. If yes, how many cigarettes smoked PER DAY now? Cuantos cigarros al dia?<br>b. If you quit smoking, when did you quit? / si dejo de fumar, cuando fue eso? | ☐ YES / SI ☐ No<br>Cig/Day ________<br>Date Quit ______ |
| 15. ALCOHOL USE I USO DE ALCOHOL | |
| a. ALCOHOL USE CURRENTLY / PRESENTE | ☐ YES / SI ☐ No |
| b. ALCOHOL USE BEFORE PREGNANCY / USO DE ALCOHOL ANTES DE EMBARAZO | ☐ YES / SI ☐ No |

| | |
|---|---|
| 16. ILLICIT DRUG USE I USO DE DROGAS<br>a. ILLICIT DRUG USE CURRENTLY / PRESENTE<br>b. ILLICIT DRUG USE BEFORE PREGNANCY / USO DE DROGAS ANTES DE EMBARAZO | <br>☐ YES / SI ☐ No<br>☐ YES / SI ☐ No |
| 18. ASTHMA, TUBERCULOSIS or LUNG PROBLEMS<br>ASMA, TUBERCULOSIS, o PROBLEMAS DE PULMONES | ☐ YES / SI ☐ No |
| 19. HAY FEVER or SEASONAL ALLERGIES / FIEBRE DEL HENO o ALERGIAS ESTACIONALES | ☐ YES / SI ☐ No |
| 20. A. ALLERGIES TO ANY MEDICATIONS / ALERGIAS A UN MEDICAMENTO<br>If yes, please specify ______________________________<br>B. ALLERGIES TO LATEX I ALERGIAS A LATEX (GUANTES DE ULE) | ☐ YES / SI ☐ No |
| 21. BREAST IMPLANTS, BREAST SURGERY or ANY PROBLEMS<br>IMPLANTES, CIRUJIA, o PROBLEMAS DE LOS SENOS | ☐ YES / SI ☐ No |
| 22. GYNECOLOGIC SURGERY (cervix, uterus, tubes, ovaries- DESCRIBE BELOW)<br>This includes freezing of the cervix {CRYO), cone biopsy of the cervix or LEEP,<br>ovarian or tubal surgery I CIRUJIA GINECOLOGICA (utero, ovarios, cervical) | ☐ YES / SI ☐ No |
| 23. ANY OTHER OPERATIONS or HOSPITALIZATIONS (DESCRIBE:· BELOW)<br>CUALQUIER OTRA OPERACION o HOSPITALIZACION | ☐ YES / SI ☐ No |
| 24. ANESTHESIA COMPLICATIONS / COMPLICACIONES DEVIDO A LA ANESTESIA | ☐ YES / SI ☐ No |
| 25. HISTORY OF ABNORMAL PAP SMEAR / PAPANICOLADO ABNORMAL | ☐ YES / SI ☐ No |
| 26. ABNORMAL UTERUS (fibroids, congenital problems, DES daughter)<br>UTERO ABNORMAL (problemas congenitales, tumor) | ☐ YES / SI ☐ No |
| 27. INFERTILITY or PROBLEMS GETTING PREGNANT / INFERTILIOAD | ☐ YES / SI ☐ No |
| 28. IN-VITRO FERTILIZATION / FERTILIZACION IN-VITRO | ☐ YES / SI ☐ No |
| 29. ANY TYPE OF CANCER or MALIGNANCY / ALGUN TIPO DE CANCER MALIGNO | ☐ YES / SI ☐ No |
| 30. EASY BLEEDING or BRUISING BEFORE PREGNANCY<br>SANGRA o SE MORENTONEA FACILMENTE | ☐ YES / SI ☐ No |
| 31. CHEMOTHERAPY or RADIATION TREATMENTS / QUIMIOTERAPIA o RADIACION | ☐ YES / SI ☐ No |
| 32. DIETARY RESTRICTIONS or FOOD INTOLERANCES / RESTRICCIONES DE DIETA | ☐ YES / SI ☐ No |
| 33. ANY CONDITION NOT MENTIONED IN THIS QUESTIONAIRRE (DESCRIBE BELOW)<br>ALGUNA CONDICION NO MENSIONADA | ☐ YES / SI ☐ No |

COMMENTS (please explain any YES answers above)
COMMENT ARIOS (Explique todas sus respuestas "Si")

______________________________________________________________________

______________________________________________________________________

## Pregnancy History

Current Pregnancy

Circle appropriate answer or fill in blanks

If IVF Pregnancy

Last Menstrual Period ______________________

Due Date ______________________

**Method of conception** –

Spont AID AIH IVF GIFT ICSI meds

**Donation of one's own eggs?**

☐ Yes ☐ No

Date of egg donor ____________

Date of egg collection/embryo Freezing ____________

Implantation date ____________