HEALTH INFORMATION FORM

Envision PHYSICIAN SERVICES
DELIVERED BY NORTH TEXAS PERINATAL ASSOCIATES, P.A.

Today's Date: _____

Last Name:	First Name:	M.I.:
Date of Birth:	Age:	Baby's Father's Age:
Referring Physician:	Estimated Due Date:	
First Day of Last Menstrual Cycle (Full Date):		
Reason For Consultation:		
Pregnancy Complications:		
Are you allergic to any medication?	❑ YES ❑ No	If YES, indicate:
Height: (Inches)	Weight: (lbs.)	

ALL Past Pregnancies, Miscarriages or Abortions					
Year	Wks at Delivery	Birth Weight	Gender	Type	Complications, Birth Defects and/or Reason for C-Section
1)			M / F	Vaginal/C-Section	
2)			M / F	Vaginal/C-Section	
3)			M / F	Vaginal/C-Section	
4)			M / F	Vaginal/C-Section	
5)			M / F	Vaginal/C-Section	

Medical History, Do you or have you had any of the following?					
Abnormal Uterus/Fibroids	Y / N	High Blood Pressure	Y / N	Kidney Disease	Y / N
Incompetent Cervix	Y / N	Asthma	Y / N	Hepatitis/Liver Disease	Y / N
Prior Cervical/Uterine Surgery	Y / N	Lupus/Rheumatoid Arthritis	Y / N	Inflammatory Bowel Disease	Y / N
IVF or Donor Eggs	Y / N	Diabetes/Gestational Diabetes	Y / N	Seizure Disorder/Epilepsy	Y / N
Genetic Disorders	Y / N	Cancer	Y / N	Thyroid Disease	Y / N
Anemia/Blood Transfusions	Y / N	Blood Clots/Pulmonary Embolism	Y / N	Anxiety/Bipolar/Depression	Y / N
Heart Disease/Murmur	Y / N	Thrombophilia	Y / N	HIV	Y / N
Other:					

Operations - Surgeries			
Date	Procedure	Date	Procedure

Genetic History
Ethnicity: African American / Asian / Cajun / Caucasian / French Canadian / Hispanic / Jewish / Mediterranean / Other:
Baby's Father's Ethnicity: African American / Asian / Cajun / Caucasian / French Canadian / Hispanic / Jewish / Mediterranean / Other:

Please answer the following questions:	
Have you had any medication exposure during the pregnancy?	Y / N
Have you had any x-ray exposure during the pregnancy?	Y / N
Have you had a rash or fever during the pregnancy?	Y / N

Patient Name: DOB:

Referring Physician: eCW MR #:

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Do you, the baby's father or any family member have any of the following?			
Intellectual Disability	Y / N	Down Syndrome	Y / N
Fragile X	Y / N	Tay Sachs	Y / N
Mediterranean Anemia	Y / N	Sickle Cell Disease	Y / N
Cystic Fibrosis	Y / N	Muscular Dystrophy	Y / N
Neural Tube Defect	Y / N	Heart Defect	Y / N
Birth Defect	Y / N	Other:	Y / N
Have you had CF Carrier Testing?	Y / N	Have you had any other genetic testing?	Y / N
If so, what were the results?		If so, what test(s) and what were the results?	

Social History – Do you or have you used any of the following during your pregnancy?			
Alcohol	Y / N	Regular Exercise	Y / N
Tobacco	Y / N	Seat Belt Use	Y / N
Drug Use	Y / N	Other:	

Review of Systems – Please check any of the following that CURRENTLY apply.			
Constitutional		**Genitourinary**	
Fatigue		Dysuria (Painful Urination):	
Fever		Frequency	
Weight Gain		Hematuria (Blood in Urine)	
Weight Loss		Urgency	
Eyes		**Muscle-Skeletal**	
Double Vision		Pain	
Glasses / Contacts		Spasm	
Seeing Spots		Weakness	
Vision Changes		**Neurological**	
Ears-Nose-Throat		Numbness	
Headache(s)		Seizures	
Sinusitis (Sinus Infection)		Syncope (Fainting)	
Tinnitus (Ringing in Ears)		Difficulty Walking	
Ulcers		**Hematologic**	
Cardiovascular		Adenopathy (Enlargement of Lymph Node)	
Chest Pain		Bleeding	
Edema (Ex: Swelling of Legs)		Bruising (Frequent)	
Orthopnea (Shortness of Breath)		**Endocrine**	
Palpitations (Abnormal Heart Beat)		Diabetes Mellitus	
Respiratory		Hyperthyroid (Over Active Thyroid)	
Coughing		Hypothyroid (Under Active Thyroid)	
Shortness of Breath		**Psychiatric**	
Wheezing		Anxiety	
Gastrointestinal		Bipolar	
Constipation		Depression	
Diarrhea		**Skin**	
Nausea		Rash	
Pain		Striae (Stretch Marks)	
Vomiting		Ulcer	
Other:			

Patient Signature Date

Physician Signature Date