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

Hospitalizations	Reason	Date

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

_____

_____

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