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OB PATIENT QUESTIONNAIRE

Patient Name _____ Today's Date ___/___/___

Date of Birth ___/___/___ Age _____ Ethnicity _____ Martial Status Single | Married | Living with Partner

Address _____

Home Phone _____ Work Phone _____ Cell phone _____

Place of Employment/Occupation _____

Emergency Contact: Home _____ Work _____ Cell _____

Father of Baby _____ Involved with Pregnancy? Y | N Date of Birth ___/___/___ Age _____

Father's Occupation _____ Work _____ Cell _____

MEDICAL HISTORY

PAST MEDICAL HISTORY

PAST SURGICAL HISTORY (YEAR & EXPLAIN)

MEDICATIONS

(LIST ALL MEDICATIONS/SUPPLEMENTS YOU ARE CURRENTLY TAKING)

DRUG ALLERGIES & REACTION

DO YOU HAVE A RELIGIOUS OBJECTION TO RECEIVING BLOOD? Y N

PAP Last test ___/___/___ Ever had an abnormal result? Y N Colposcopy Y N Cryo/LEEP Y N

CONTRACEPTIVE HISTORY Current/Previous Method _____

OBSTETRICAL HISTORY # of Pregnancies _____ Premature Babies _____ Miscarriages _____ Abortions _____ Living Children _____

DATE	#WEEKS	WEIGHT	SEX	TYPE OF DELIVERY	COMPLICATIONS WITH PREGNANCY	COMPLICATIONS WITH DELIVERY
1.						
2.						
3.						
4.						
5.						
6.						

Patient Name: _____

RISK FACTORS FOR PREGNANCY

List any over-the-counter medications used since your last period: _____

List any prescriptions medications used since your last period: _____

Have you had any X-rays since your last period?	Y <input type="checkbox"/>	N <input type="checkbox"/>	Explain: _____
Do you have contact with cat litter (feces) or eat raw or uncooked meats?	Y <input type="checkbox"/>	N <input type="checkbox"/>	_____
Have you ever experimented with marijuana, cocaine, or other illicit drugs?	Y <input type="checkbox"/>	N <input type="checkbox"/>	_____
Have you been exposed to marijuana, cocaine, or other illicit drugs since your last period?	Y <input type="checkbox"/>	N <input type="checkbox"/>	_____

PAST MEDICAL & FAMILY HISTORY (PLEASE CHECK IF YOU (SELF) OR ANY BLOOD RELATIVE (FAM) HAVE ANY OF THE FOLLOWING):

	SELF	FAM	EXPLAIN		SELF	FAM	EXPLAIN
Headaches	<input type="checkbox"/>	<input type="checkbox"/>		Blood transfusions	<input type="checkbox"/>	<input type="checkbox"/>	
Heart/Vascular disease	<input type="checkbox"/>	<input type="checkbox"/>		Anemia/Blood disorder	<input type="checkbox"/>	<input type="checkbox"/>	
Rheumatic disease	<input type="checkbox"/>	<input type="checkbox"/>		Stroke	<input type="checkbox"/>	<input type="checkbox"/>	
High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>		DVT/ Pulmonary Embolism	<input type="checkbox"/>	<input type="checkbox"/>	
High Cholesterol	<input type="checkbox"/>	<input type="checkbox"/>		Skin disease	<input type="checkbox"/>	<input type="checkbox"/>	
Respiratory disease	<input type="checkbox"/>	<input type="checkbox"/>		Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	
Pulmonary /asthma	<input type="checkbox"/>	<input type="checkbox"/>		Thyroid disease	<input type="checkbox"/>	<input type="checkbox"/>	
Breast Cancer	<input type="checkbox"/>	<input type="checkbox"/>		Cancer (type)	<input type="checkbox"/>	<input type="checkbox"/>	
Jaundice/Hepatitis	<input type="checkbox"/>	<input type="checkbox"/>		Uterine or Ovarian Cancer	<input type="checkbox"/>	<input type="checkbox"/>	
Reflux/Ulcer	<input type="checkbox"/>	<input type="checkbox"/>		Epilepsy/Neurologic disease	<input type="checkbox"/>	<input type="checkbox"/>	
Bowel disease/Colon Cancer	<input type="checkbox"/>	<input type="checkbox"/>		Arthritis – Joint pain	<input type="checkbox"/>	<input type="checkbox"/>	
Kidney disease	<input type="checkbox"/>	<input type="checkbox"/>		Osteoporosis/Joint Problems	<input type="checkbox"/>	<input type="checkbox"/>	
Urinary Incontinence	<input type="checkbox"/>	<input type="checkbox"/>		Anxiety/Depression	<input type="checkbox"/>	<input type="checkbox"/>	
Urinary Infections	<input type="checkbox"/>	<input type="checkbox"/>		Sleep Problems	<input type="checkbox"/>	<input type="checkbox"/>	
STD	<input type="checkbox"/>	Partner? <input type="checkbox"/>		Genital Herpes	<input type="checkbox"/>	Partner? <input type="checkbox"/>	

VACCINES: COVID-19 | Chicken Pox | Childhood Vaccines | HPV | Hepatitis A | Hepatitis B | Last Tetanus: _____

SOCIAL HISTORY: Smoking – Cig./Day _____ # Years _____ Alcohol – Oz/Week _____ Caffeine – Cup/Day _____

GENETIC AND INFECTION SCREENING:

	Y	N		Y	N
Patient's Age Will Be 35 Or Older at EDD			Maternal Metabolic Disorder (e.g. Type 1 Diabetes, PKU)		
Thalassemia (Italian, Greek, or Asian Background): MCV <80			Patient or Baby's Father Has a Child with Birth Defects		
Neural Tube Defect (e.g. Spina Bifida/Anencephaly)			Recurrent Pregnancy Loss, or A Stillbirth		
Congenital Heart Defect			Medications (see list on 1 st page)		
Down Syndrome			If Yes, Agent(s) And Strength/Dosage (see list on 1 st page)		
Tay-Sachs (e.g. Jewish, Cajun, French-Canadian)			Any Other Genetic History		
Canavan Disease			Live With Someone with TB or Exposed to TB		
Sickle Cell Disease or Trait (African)			Patient or Partner Has History of Genital Herpes		
Hemophilia or Other Blood Disorders			Rash or Viral Illness Since Last Menstrual Period		
Muscular Dystrophy			History of STD, Gonorrhea, Chlamydia, HPV, Syphilis		
Cystic Fibrosis			Other Infection History		
Huntington's Chorea			History of HIV		
Intellectual Disability/Autism			History of Hepatitis		
If <u>Yes</u> , was person Tested for Fragile X?			Prior GBS-infected child		
Other Inherited Genetic or Chromosomal Disorder					

HAVE THERE BEEN ANY STILLBIRTHS IN EITHER OF YOUR FAMILIES? Y N

HAS ANYONE HAD MORE THAN TWO MISCARRIAGES IN EITHER OF YOUR FAMILIES? Y N

IS THERE ANYTHING GENETIC YOU ARE CONCERNED ABOUT? Y N Explain: _____

IF YOU ARE BLOOD rH NEGATIVE, DID YOU RECEIVE Rhogam AFTER EACH PREGNANCY (include miscarriages and abortions)? Y N