OB Questionnaire

Name_____ Age: _____ DOB: ___/___/___ Height_____ Date: ___/___/____

PCP: _____ Last menstrual period: _____

Reason for your visit today: _____ **Pharmacy:** _____

☐ Check Box for ***No Known Drug Allergies***

☐ Check Box for *** **LATEX** Allergy***

List all Allergies & Adverse Reactions

Drug/Allergen Reaction

_____

_____

Vaccine Immunization (Flu, Tdap, etc…) **& Date received**

_____

List all Medications/Supplements/Herbal and Dosage

_____

_____

_____

Surgical History (C/S, Appendix, Tubal, Dental, etc…)

Procedure Surgery Date

_____

_____

Past Medical History

- □ Abuse/Domestic Violence
- □ Acid Reflux (GERD)
- □ Acne
- □ Anemia
- □ Anesthesia Complications
- □ Anxiety Disorder
- □ Arthritis
- □ Asthma
- □ Autoimmune Disorders
- □ Birth Defects or Inherited Disease
- □ Blood Transfusions
- □ Breast Cancer
- □ Breast Problem
- □ Cancer
- □ Chronic ear infections
- □ Colon Cancer
- □ Depression
- □ Diabetes
- □ Difficulty swallowing
- □ Eating Disorder
- □ Eczema
- □ Endometriosis
- □ Fibromyalgia
- □ GI Problems
- □ Headaches/Migraines
- □ Heart Attack
- □ Heart Disease
- □ Heart Problems
- □ Hepatitis
- □ High Cholesterol
- □ Hypertension
- □ Infertility
- □ Kidney Disease
- □ Kidney or Bladder Problems
- □ Lung Disease
- □ Lupus
- □ Melanoma
- □ Meniere's disease
- □ Nasal polyps
- □ Osteoporosis
- □ Ovarian Cancer
- □ Polyps
- □ Pre-Eclampsia/ Toxemia
- □ Psychiatric Illness
- □ Rheumatoid Arthritis
- □ Stroke
- □ Thrombophilia/ Blood clots
- □ Thyroid Problems
- □ Varicosities
- □ Other_____
_____
_____
_____

Family History

M-Mother **F**-Father **Son**-Son **D**-Daughter **S**-Sister **B**-Brother **MGM**-Maternal Grandmother **MGF**-Maternal Grandfather **MA**-Maternal Aunt **MU**- Maternal Uncle **O**-Other Relative **PGM**-Paternal Grandmother **PGF**-Paternal Grandfather **PA**- Paternal Aunt **PU**-Paternal Uncle

Diabetes -	**GI Problems -**
High Blood Pressure -	**Psychiatric Illness -**
Heart Disease -	**Depression -**
Heart Attack -	**Birth Defect -**
High cholesterol -	**Osteoporosis -**
Stroke -	**Breast cancer -**
Thyroid Problems -	**Ovarian cancer -**
Lung Disease -	**Colon cancer -**
Asthma -	**Lung Cancer -**
Arthritis -	**Pancreatic Cancer -**
Seizure Disorder -	**Drug or Alcohol Abuse -**

Social History

1. Deaf or serious difficulty hearing: ☐Yes ☐No
2. Blind or serious difficulty seeing: ☐Yes ☐No
3. Difficulty concentrating, remembering or making decisions ☐Yes ☐No
4. Difficulty walking or climbing stairs ☐Yes ☐No
5. Difficulty dressing or bathing ☐Yes ☐No
6. Difficulty doing errands alone ☐Yes ☐No
7. Are you currently employed? ☐Yes ☐No
8. Occupation: _____
9. Education: _____
10. Relationship Status:
    ☐Married ☐Single ☐Divorced
    ☐Separated ☐Widowed ☐Domestic partner
11. Live alone or with others? ☐Alone ☐with others
12. Number of children: _____
13. Exercise level:
    ☐None ☐Occasional ☐Moderate ☐Heavy
14. Diet:
    ☐Regular ☐Vegetarian ☐Vegan
    ☐Gluten free ☐Diabetic ☐Cardiac
    ☐Specific ☐Carbohydrate
15. General stress level: ☐Low ☐ Medium ☐ High
16. Smoking Status:
    ☐ Never ☐ Former ☐ Current- every day
17. Smoking - How much?
    ☐None ☐1PPW ☐2PPW
18. Tobacco-years of use: _____
19. Smoking pre-pregnancy: ☐Yes ☐No
20. Has smoked since age: _____
21. Chewing tobacco ☐Yes ☐No
22. Alcohol pre-pregnancy
    ☐ None ☐Occasional ☐Moderate ☐Heavy
23. Alcohol intake:
    ☐ None ☐Occasional ☐Moderate ☐Heavy
24. Alcohol-years of use: _____
25. Caffeine intake:
    ☐ None ☐Occasional ☐Moderate ☐Heavy
26. Illicit drugs pre-pregnancy ☐Yes ☐No
27. Illicit drugs _____
28. Illicit drugs-years of use _____
29. Seat belts used routinely ☐Yes ☐No
30. Sunscreen used routinely ☐Yes ☐No
31. Is anesthesia consult planned? ☐Yes ☐No
32. Is blood transfusion acceptable in an emergency? ☐Yes ☐No
33. Advance directive ☐Yes ☐No
34. Sexually active? ☐Yes ☐No
35. Birth plan ☐Yes ☐No
36. Live with cats/exposure to cat litter? ☐Yes ☐No
37. Changes in family/social situation ☐Yes ☐No
38. Frequent air travel ☐Yes ☐No
39. Occupational health risks ☐Yes ☐No
40. Passive smoke exposure? ☐Yes ☐No
41. Smoke/CO detectors in home? ☐Yes ☐No

Obstetric History

Have you ever been pregnant? ☐Yes ☐No

How Many times have you been pregnant? _____

Full Term _____ Miscarriages ____ Ectopic Preg ____ Living children ___

Premature _____ Abortions _____ Multiples _____

Date	# Fetuses	Gestational age	Labor Length	Birth Weight	Sex	Delivery Type	Anesthesia	Complications (e.g. Preterm labor, diabetes, high blood pressure)
		Full / Preterm			M / F	Vag / C-Sec		
		Full / Preterm			M / F	Vag / C-Sec		
		Full / Preterm			M / F	Vag / C-Sec		
		Full / Preterm			M / F	Vag / C-Sec		
		Full / Preterm			M / F	Vag / C-Sec		

Husband/Domestic partner: _____ Phone: _____

Pediatrician: _____ Phone: _____

Genetic Screening and Infection History

1. Patient's Age: _____
2. Will patient be 35 years or older at Estimated Date of Delivery ☐Yes ☐No
3. Thalassemia (Italian, Greek, Mediterranean, or Asian Background): ☐Yes ☐No
4. Neural Tube Defect (Meningomyelocele, Spina Bifida, Or Anencephaly) ☐Yes ☐No
5. Congenital Heart Defect ☐Yes ☐No
6. Down Syndrome ☐Yes ☐No
7. Tay-Sachs (eg, Jewish, Cajun, French-Canadian) ☐Yes ☐No
8. Canavan Disease ☐Yes ☐No
9. Sickle Cell Anemia ☐Yes ☐No
10. Hemophilia or other blood disorders ☐Yes ☐No
11. Muscular Dystrophy ☐Yes ☐No
12. Cystic Fibrosis ☐Yes ☐No
13. Huntington's Chorea ☐Yes ☐No
14. Mental Retardation/Autism ☐Yes ☐No
15. If Yes, Was Person Tested for Fragile X? ☐Yes ☐No
16. Other Inherited Genetic Or Chromosomal Disorder ☐Yes ☐No
17. Maternal Metabolic Disorder (e.g., Type 1 Diabetes, PKU ☐Yes ☐No
18. Has patient or baby's father had a child with birth defects not listed above ☐Yes ☐No
19. Recurrent pregnancy loss, or a stillbirth ☐Yes ☐No
20. Have you taken any Medications (including Supplements, Vitamins, Herbs, OTC Drugs), Illicit/Recreational Drugs, Alcohol ☐Yes ☐No
    If Yes, Agent(s) And Strength/Dosage
    _____
    _____
21. Do you live with someone with TB or been exposed to TB ☐Yes ☐No
22. Do you or your partner have a history of genital Herpes ☐Yes ☐No
23. Have you had a rash or viral illness since last menstrual period ☐Yes ☐No
24. History of STD, Gonorrhea, Chlamydia, HPV, Syphilis ☐Yes ☐No
25. Other Infection History _____
    _____

GYN History

1. Last menstrual period: _____
2. LMP ☐Unknown ☐Approximate ☐Definite
3. Menses Monthly: ☐Yes ☐No
4. Flow: ☐Light ☐Normal ☐ Heavy
5. Duration of flow (days) _____
6. Frequency of cycle (Q days) _____
7. What age did you start your period _____
8. List your age with first child _____
9. Date of last pap smear _____
10. Abnormal Pap: ☐Yes ☐No
    When? _____
11. Cervical biopsy: ☐Yes ☐No
12. Leep or Cryo Therapy ☐Yes ☐No
13. HPV Vaccine ☐Yes ☐No
14. Sexual problems? ☐Yes ☐No
15. History of STDs: ☐Yes ☐No
    Choose all that apply:
    HPV/Chlamydia/Herpes/Gonorrhea/
    Trichomonas/Syphilis/Hepatitis/HIV
    Date Treated_____
16. Hernia Repair ☐Yes ☐No
17. Staph/MRSA infection ☐Yes ☐No
18. Ovarian Cysts ☐Yes ☐No
19. Ovary(ies) removed ☐Right ☐Left ☐both
20. Uterine fibroids ☐Yes ☐No
21. Endometriosis ☐Yes ☐No
22. Vaginal infection ☐Yes ☐No
23. Loss of urine w/ coughing or straining ☐Yes ☐No
24. Bladder repair ☐Yes ☐No
25. Breast lump or biopsy ☐Yes ☐No
26. Bartholin Gland Cyst/ Removal ☐Yes ☐No
27. Urinary Tract Infection ☐Yes ☐No
28. Problem with excess hair ☐Yes ☐No
29. Date of last mammogram _____
30. Date of last colonoscopy _____