OB PATIENT QUIESTIONNAIRE

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

DOB: ____/____/_____ Age ___ Ethnicity _____ Marital Status: Single □ Married □ Living w Partner □

Address _____

Home Phone _____ Work _____ Cell _____

Place of Employment / Occupation _____ Hours worked/week _____

Emergency Contact: Home Phone _____ Work _____ Cell _____

Father of Baby _____ Involved in Pregnancy? Y □ N □ DOB: __/____/_____Age:_____

Father's Occupation _____ Work _____ Cell _____

Medical History

Past Medical History

_____ _____

_____ _____

_____ _____

Past Surgical History

Year Explain _____ Year Explain _____

Year Explain _____ Year Explain _____

Medications: Lists all medications you are currently taking

_____

_____

_____

Allergies & Reactions:

_____

_____

_____

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

PAP Last Test _ /__ /__ Ever had abnormal Result? Y □ N □ **Colposcopy** Y □ N □ **Cryo/LEEP** Y □ N □

Contraceptive History Current Method? _____

Obstetrical History # of Pregnancies ____ Premature _____ Miscarriages ___ Abortions ____ Living Children _____

BIRTH DATE	WEEKS	WT.	SEX	TYPE OF DELIVERY	COMPLICATIONS WITH PREGNANCY	COMPLICATIONS WITH DELIVERY

Any Pregnancy Complications? Diabetes □ Hypertension/High blood Pressure □ Pre-eclampsia/Toxemia □ Other □

Any History of Depression before of after pregnancy? Y □ N □ , How Treated? _____

IF YOU ARE Rh NEGATIVE, DID YOU RECEIVE RhoGam AFTER EACH PREGNANCY (INCLUDE MISCARRIAGES, ABORTIONS) Y □ N □

Risk Factors for pregnancy

How old will you be on your due date? _____

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

List any prescription drugs used since your last period: _____

Have you had any X-rays since your last period? Y □ N □

Do you have contact with cat litter (feces), or eat raw or uncooked meats? Y □ N □

Have you ever experimented with marijuana, cocaine, or street drugs? Y □ N □

Have you been exposed to marijuana, cocaine, or street drugs since your last period? Y □ N □

Past Medical & Family History Please check (**√**)if you (SELF) or any blood relative (FAM) had any of the following

	SELF	FAM	EXPLAIN		SELF	FAM	EXPLAIN
Headaches	□	□		Blood Transfusions	□	□	
Heart / Vascular	□	□		Anemia/ Blood Disorder	□	□	
Rheumatic Disease	□	□		Stroke	□	□	
High Blood Pressure	□	□		DVT/Pulmonary Embolism	□	□	
High Cholesterol	□	□		Skin Disease	□	□	
Respiratory Disease	□	□		Diabetes	□	□	
Pulmonary (Lung) / Asthma	□	□		Thyroid Disease	□	□	
Breast Cancer	□	□		Cancer (Type)	□	□	
Jaundice / Hepatitis	□	□		Uterine/Ovarian Cancer	□	□	
Reflux / Ulcer	□	□		Epilepsy/ Neurological Disease	□	□	
Bowel Disease / Colon Cancer	□	□		Arthritis - Joint Pain	□	□	
Kidney Disease	□	□		Osteoporosis	□	□	
Urinary Incontinence	□	□		Anxiety / Depression	□	□	
Urinary Infections	□	□		Sleep Problems	□	□	
STD	□	Partner? □		Genital Herpes	□	Partner? □	

Vaccines : Chicken Pox □ Childhood Vaccines □ HPV □ Hepatitis A □ Hepatitis B□ Last Tetanus? _____

Social History Smoking - cig/day _____ # years _____ Alcohol - Oz./Week _____ Caffeinated Beverages- Cups/Day _____

HAS ANYONE IN YOUR OR FATHER OF THE BABY'S FAMILY HAD:

Down's Syndrome	Y □ N □	Mental Retardation	Y □ N □	Spina Bifida (open spine)	Y □ N □
Hemophilia (free bleeding)	Y □ N □	Muscular Dystrophy	Y □ N □	Neurological Disorders	Y □ N □
Cystic Fibrosis	Y □ N □	Deafness or Blindness	Y □ N □	Hydrocephalus (water in brain)	Y □ N □
Chromosome Abnormality	Y □ N □	Cleft Lip or Palate	Y □ N □	Sickle Cell Anemia / Thalassemia	Y □ N □
Congenital Heart Defect	Y □ N □	Anencephaly (open brain)	Y □ N □		

Any other birth defects (even ones surgically corrected): _____

Any other inherited problems: _____

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 □

ARE YOU OR THE FATHER OF THE BABY:

Jewish	Y □ N □	If yes, have either of you had Tays-Sachs carrier Screening?	Y □ N □
Aftican-American or East Indian?	Y □ N □	If yes, have either of you been screened for the sickle cell trait?	Y □ N □
Italian or Greek?	Y □ N □	If yes, have either of you had thalassemia carrier testing?	Y □ N □

Is there anything genetic you are concerned? _____