OB Health Questionnaire

Please complete the following information:

Name:	Date:
Referring Physician:	Primary Care Provider:
Date of Birth:	Age:
Race: ☐ Caucasian ☐ African American ☐ Hispanic ☐ Asian ☐ Other If other, please specify:	Marital Status: ☐ Single ☐ Married ☐ Widowed ☐ Divorced ☐ Separated
Phone Number:	Email address:
Preferred Pharmacy Name:	Preferred Pharmacy Number:
Occupation:	Education(last grade completed):
Language:	Emergency Contact:
Husband/Partner Name:	Emergency Contact Number:
Husband/Partner Number:	Best Number to Reach You:
Father of Baby: ☐ check if same as above	Father of Baby Number: ☐ check if same as above
MENSTRUAL HISTORY	
First Day of last menstrual period: Check if normal amount/duration: ☐	Do you have monthly menstrual cycles? ☐ Yes ☐ No
How certain are you of your last menstrual cycle? ☐ Definite ☐ Uknown ☐ Approximate (month known)	Were you taking birth control when pregnancy determined? ☐ Yes ☐ No If yes, what type?
Age when periods began:	Number of days between periods:
Positive Pregnancy test: ☐ Yes ☐ No If yes, what date?	Type of pregnancy test: ☐ Urine ☐ Blood

SOCIAL HISTORY			
Do you use tobacco? ☐Yes ☐ No	What type? ☐cigarettes ☐ chewing	For how many years?	How much per day?
Did you previously use tobacco? ☐ Yes ☐ No		For how many years?	When did you quit?
Do you use alcohol ☐ Yes ☐ No		For how many years?	How much per day?
Do you use illicit drugs? ☐ Yes ☐ No What type: ☐ Marijuana ☐ Cocaine ☐ Heroine ☐ Amphetamines ☐Other		For how many years?	How much per day?
Reviewers Name:		**Reviewers Signature:**	

PAST PREGNANCIES			
# of times pregnant:	# of term pregnancies:	#of deliveries prior to 37 weeks:	# of elective abortions:
# of miscarriages:	# of ectopic pregnancies:	# of multiple births:	# of living children:

PREGNANCY DETAILS #1			**PREGNANCY DETAILS #2**		
Date: #of weeks at delivery: Length of Labor: Birth Weight: Sex of child: □ M □ F	Type of Delivery: □Vaginal □C-Section □Elective abortion □Miscarriage Anesthesia: □ Spinal □Epidural	Complications: □Gestational diabetes □Preeclampsia □Eclampsia □Hyperemesis gravidarum □Preterm labor □Preterm delivery □Incompetent cervix	Date: #of weeks at delivery: Length of Labor: Birth Weight: Sex of child: □ M □ F	Type of Delivery: □ Vaginal □ C-Section □ Elective abortion □ Miscarriage Anesthesia: □ Spinal □ Epidural	Complications: □ Gestational diabetes □ Preeclampsia □ Eclampsia □ Hyperemesis gravidarum □ Preterm labor □ Preterm delivery □ Incompetent cervix
Place of delivery:			Place of delivery:		

PREGNANCY DETAILS #3			**PREGNANCY DETAILS #4**		
Date: #of weeks at delivery: Length of Labor: Birth Weight: Sex of child: □ M □ F	Type of Delivery: □Vaginal □C-Section □Elective abortion □Miscarriage Anesthesia: □ Spinal □Epidural	Complications: □Gestational diabetes □Preeclampsia □Eclampsia □Hyperemesis gravidarum □Preterm labor □Preterm delivery □Incompetent cervix	Date: #of weeks at delivery: Length of Labor: Birth Weight: Sex of child: □ M □ F	Type of Delivery: □ Vaginal □ C-Section □ Elective abortion □ Miscarriage Anesthesia: □ Spinal □ Epidural	Complications: □ Gestational diabetes □ Preeclampsia □ Eclampsia □ Hyperemesis gravidarum □ Preterm labor □ Preterm delivery □ Incompetent cervix
Place of delivery:			Place of delivery:		

PREGNANCY DETAILS #5			**PREGNANCY DETAILS #6**		
Date: #of weeks at delivery: Length of Labor: Birth Weight: Sex of child: □ M □ F	Type of Delivery: □Vaginal □C-Section □Elective abortion □Miscarriage Anesthesia: □ Spinal □Epidural	Complications: □Gestational diabetes □Preeclampsia □Eclampsia □Hyperemesis gravidarum □Preterm labor □Preterm delivery □Incompetent cervix	Date: #of weeks at delivery: Length of Labor: Birth Weight: Sex of child: □ M □ F	Type of Delivery: □ Vaginal □ C-Section □ Elective abortion □ Miscarriage Anesthesia: □ Spinal □ Epidural	Complications: □ Gestational diabetes □ Preeclampsia □ Eclampsia □ Hyperemesis gravidarum □ Preterm labor □ Preterm delivery □ Incompetent cervix
Reviewer's Name:			**Reviewer's Signature:**		

MEDICAL HISTORY

Please check any current or past medical problems for yourself:

	Yes	**No**		**Yes**	**No**
Diabetes			RH Sensitization		
Hypertension			Asthma		
Heart Disease			Lung problems		
Autoimmune Disorder			Seasonal Allergies		
Kidney Disease			Neurologic Disease		
Seizures			Psychiatric Disease		
Postpartum Depression			Depression		
	Yes	**No**		**Yes**	**No**
Hepatitis			Liver Disease		
Blood clots in the legs/lungs			Spider Veins		
Thyroid Disorder			Trauma		
Domestic Violence			History of Blood Transfusion		
Drug Allergies			Latex Allergy		
Previous gynecologic surgery			Previous surgery:		
If yes, please list:			If yes, please list:		
Anesthetic complications			History of abnormal pap smear		
Uterine Anomalies			Infertility		
Family History			Other		

Comments:

CURRENT MEDICATIONS

Please list any medications you are taking including prenatal vitamins, birth control pills, Tylenol, Advil, Aspirin, herbal and non-prescription medications

Medication Name	Dose	Frequency	Medication Name	Dose	Frequency

Do you have any medication allergies? □ Yes □ No	If yes, to what?	What type of reaction do you have?
Do you have any food/latex allergies?	If yes, to what?	What type of reaction do you have?

Is a blood transfusion acceptable in an emergency situation? □ Yes □ No

Reviewer's Name:	**Reviewer's Signature:**

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GENETIC SCREENING					
Include patient, baby's father or anyone in either family					
	Yes	**No**		**Yes**	**No**
Will you be older than 35 at the time of delivery?			Huntington's Chorea		
Thalassemia (Italian, Greek, Mediterranean background)			Mental Retardation/Austism		
Neural Tube Defects (spina bifida, meningomyelocele)			If mental retardation, was person tested for Fragile X?		
Congenital Heart Defect?			Maternal Metabolic Disorder (Type I diabetes, PKU)		
Down Syndrome			Patient or baby's father had a child with birth defects		
Tay-Sachs (Jewish, French Canadian)			Recurrent Pregnancy loss or a stillbirth		
Canavan Disease			Sickle Cell Disease or Trait (African)		
Hemophilia or other blood disorders			Muscular Dystrophy		
Cystic Fibrosis			Other inherited genetic or chromosomal disorder		
Medications used since last menstrual period (include vitamins, herbs, and non-prescription drugs)			Any other information you would like to share		
If yes, please list drug and dosage			Comments		

INFECTION HISTORY					
	Yes	**No**		**Yes**	**No**
Do you live with someone with TB or exposed to TB?			Do you or your partner have genital herpes?		
History of sexually transmitted diseases?			Have you had a rash or viral illness since pregnancy began?		
If yes, which one? □ gonorrhea □ chlamydia □ syphilis □ HPV			Have you ever had either of the following? □ Hepatitis B □ Hepatitis C		
Reviewer's Name:			**Reviewer's Signature:**		

REVIEW OF SYSTEMS (please confirm any symptoms you have had in the last month)					
	Yes	**No**		**Yes**	**No**
Constitutional Fatigue			**Urinary** Urgency		
Pre-pregnancy weight			Hematuria		
Fever			Frequency		
Weight Loss			Dysuria (painful urination)		
Weight Gain			Incontinence		
Changes in Appetite			**Skin** Changes in existing moles/lesions		
Gynecologic Vaginal bleeding			Rash		
Vaginal discharge			Itching		
Pelvic Pain			**ENT** Decreased Hearing		
Vaginal Itching			Sore Throat		
Eyes Wear glasses			**Musculoskeletal** Muscle Aches		
Wear contacts			Arthritis		
Blurred vision			Chronic Back Pain		
Neurologic Weakness			**Gastrointestinal** Nausea		
Dizziness			Vomiting		
Vertigo			Diarrhea		
Headaches			Constipation		
If yes, what type? ◻ sinus ◻ migraine ◻ tension			**Endocrine** Excessive thirst		
Breasts Lumps			Hair Loss		
Tenderness			Cold Intolerance		
Nipple Discharge			Heat Intolerance		
Cardiovascular Chest pain			**Psychiatric** Anxiety		
Irregular Heart Beat			Depression		
Palpitations			Difficulty Sleeping		
Leg swelling			**Hematologic/Lymphatic** Easy Bruising		
Respiratory Shortness of Breath			Excessive Bleeding		
Wheezing			**Allergic/Immunologic** Allergy Symptoms		
Cough			HIV risk factors(IV drug use, high risk sexual behavior)		
Reviewer's Name:			**Reviewer's Signature:**		

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