PATIENT QUESTIONNAIRE – NEW OB PATIENT

The purpose of obtaining this information is to develop a comprehensive picture of your background. By completing these questions to the best of your ability, you will make it possible for your doctor to evaluate and treat you in the best clinical manner. This sheet will become a part of your medical record and will therefore be considered CONFIDENTIAL INFORMATION.

PATIENT NAME: ____ **DATE:** ____________________

How did you learn of our practice? ____

VITAL SIGNS: First day of your last menstrual period/LMP: ____

Height: _________ How much did you weigh **before** you were pregnancy? Pre-Pregnancy Weight: _______________

Was your last period normal? ______________________ Are you certain about the date? ☐ Yes ☐ No

Last Pap smear? ______________ ☐ Normal ☐ Abnormal On Birth Control at Conception? ☐ Yes ☐ No

Date of your pregnancy test? ______________________ Was it urine? ☐ Yes ☐ No

PERSONAL MEDICAL HISTORY: *Did you or do you presently have any of the following, please circle YES or NO:*

Anemia	**YES**	**NO**	History of Sexually Transmitted Disease	**YES**	**NO**
Anemia in Pregnancy	**YES**	**NO**	High Blood Pressure/Hypertension	**YES**	**NO**
Anesthetic Complications	**YES**	**NO**	Hypertension in Pregnancy	**YES**	**NO**
Asthma	**YES**	**NO**	Infertility	**YES**	**NO**
Bleeding Disorder	**YES**	**NO**	Kidney Disease	**YES**	**NO**
Breast Disease	**YES**	**NO**	Liver Disease	**YES**	**NO**
Cancer (specify):	**YES**	**NO**	Lung Disease	**YES**	**NO**
Colitis	**YES**	**NO**	Lupus	**YES**	**NO**
Depression	**YES**	**NO**	Psychiatric Illness	**YES**	**NO**
Depression/Postpartum	**YES**	**NO**	Recurrent Urinary Tract Infections (more than 4 a year)	**YES**	**NO**
Diabetes Type I	**YES**	**NO**	Skin Disorder	**YES**	**NO**
Diabetes Type	**YES**	**NO**	Tuberculosis	**YES**	**NO**
Epilepsy	**YES**	**NO**	Thrombophlebitis/Embolism	**YES**	**NO**
Gestational Diabetes	**YES**	**NO**	Thyroid Dysfunction	**YES**	**NO**
Heart Disease	**YES**	**NO**	Trauma/Violence	**YES**	**NO**
Hepatitis	**YES**	**NO**	Ulcer	**YES**	**NO**
History of Abnormal Pap Smear	**YES**	**NO**	Uterine Abnormality	**YES**	**NO**
History of Blood Transfusion	**YES**	**NO**	**Other:**		

INFECTION HISTORY: *Please circle YES or NO to any of the following:*

Exposed to TB	**YES**	**NO**	History of HPV	**YES**	**NO**
History of Chlamydia	**YES**	**NO**	History of PID	**YES**	**NO**
History of Genital Herpes	**YES**	**NO**	History of Syphilis	**YES**	**NO**
History of Gonorrhea	**YES**	**NO**	Prior Group B Strep Infected Child	**YES**	**NO**
History of Hepatitis	**YES**	**NO**	Rash since last menstrual period	**YES**	**NO**
History of HIV	**YES**	**NO**	Viral Illness since last menstrual period	**YES**	**NO**

BLOOD TRANSFUSION IN THE PAST? ___ No ___ Yes Is a blood transfusion acceptable? ___ No ___ Yes

HOSPITALIZATIONS: Have you ever been hospitalized (not including births of babies and above listed surgeries)?

___ No ___ Yes If yes, for what and when: ____

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____

ALLERGIES/DRUG ALLERGIES: *Please list and include reactions.*___ **NONE Latex: ___ No ___ Yes**

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MEDICATIONS (with dose and frequency): *Please list any medications you have taken since your last menstrual period or first positive pregnancy test and are presently taking (attach a list if necessary).*

1.	**7.**
2.	**8.**
3.	**9.**
4.	**10.**
5.	**11.**
6.	**12.**

FAMILY MEDICAL HISTORY: *Please circle YES or NO to the following questions about your **family's history and the Father of the baby's family history**. **(This should include Uncles, Aunts, Grandparents, Cousins etc)**:*

Your Family History: Father of the Baby's Family History

YES	**NO**	Blood Disorder/Hemophilia	**YES**	**NO**
YES	**NO**	Chromosomal Anomaly/Disorder	**YES**	**NO**
YES	**NO**	Congenital Heart Defect	**YES**	**NO**
YES	**NO**	Cystic Fibrosis	**YES**	**NO**
YES	**NO**	DES Exposure		
YES	**NO**	Down Syndrome	**YES**	**NO**
YES	**NO**	Endocrine Disorder/Maternal Metabolic Disorders	**YES**	**NO**
YES	**NO**	Exposure to cat feces		
YES	**NO**	Huntington's Disease/Huntington Chorea	**YES**	**NO**
YES	**NO**	Mental Retardation	**YES**	**NO**
YES	**NO**	Muscular Dystrophy	**YES**	**NO**
YES	**NO**	Neural Tube Defect (including "water in the brain" or Spina Bifida)	**YES**	**NO**
YES	**NO**	Sickle Cell Disease	**YES**	**NO**
YES	**NO**	Sickle Cell Trait	**YES**	**NO**
YES	**NO**	Tay-Sachs Disease	**YES**	**NO**
YES	**NO**	Thalassemia	**YES**	**NO**

PERSONAL HABITS/SOCIAL HISTORY: *Please check your answer.*

Marital Status: __ Single __ Engaged __ Married __ Widowed __ Separated __ Divorced __ Living with significant other

Tobacco Use: __ Never Smoker __Former Smoker __Current Smoker __ packs per day for ___ years / Quit___ yrs ago

Alcohol Use: ___ None ___ Occasional Use ___ Moderate Use ___ Heavy Use _____ drinks per week

Street Drug Use: ___ Yes ___ No If yes, what and how much? ____

Do you live with a cat? ___ Yes ___ No

Did you grow up with domestic violence or abuse? ___ Yes ___ No

Are you presently in a relationship that is violent or abusive? ___ Yes ___ No

Are you a Jehovah Witness? ___ Yes ___ No

PAST SURGICAL HISTORY: *Please list and date any past surgeries (including tonsillectomy).*

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____

Have you had surgery done on your uterus? **If yes, when? ____**

Have you had a cone biopsy? **If yes, when? ____**

Have you had a colposcopy? **If yes, when? ____**

Have you had a LEEP? **If yes, when? ____**

PREGNANCY/BIRTH HISTORY:

Father of the baby: ____________________________________ His phone number: ______________________________

What is his race? ____ White ____ Black ____ Hispanic ____ Arabic ____Asian _____ Other: ____________________

_____ Total Number of Pregnancies (including this one) (Gravida) _____ Deliveries (Para)

_____ Ectopic _____ Abortion _____ Miscarriage

*Please answer **only** if you have been pregnant previously:* ____ **N/A**

Question		
Have you ever had preterm labor (before 36 weeks)?	**YES**	**NO**
Has your water ruptured before 36 weeks?	**YES**	**NO**
Has your cervix been dilated before 36 weeks?	**YES**	**NO**
Have you had any prior C-Sections?	**YES**	**NO**
Have you ever needed a D&C after a baby was born?	**YES**	**NO**
Have you ever had a placenta abruption?	**YES**	**NO**
Have you ever had a positive Group B Strep culture during pregnancy?	**YES**	**NO**
Have you had a baby with a birth defect?	**YES**	**NO**
Have you had a still birth?	**YES**	**NO**

PREGNANCY/BIRTH HISTORY (continued): *Please list, in order, pregnancies by using the chart below.*

Gestational Weeks	Length of Labor	Anesthesia	Date	Sex (M/F)	Birth Weight	Place of Delivery (Hospital)	Delivery Type (Vaginal or C-section)	PT – Preterm <37 weeks FT – Full-Term > 37 weeks	M-Miscarriage A - Abortion E - Ectopic
		Y / N		M / F					
		Y / N		M / F					
		Y / N		M / F					
		Y / N		M / F					
		Y / N		M / F					
		Y / N		M / F					
		Y / N		M / F					

Please use the back of this sheet if you need more space.

MENSTUAL HISTORY

Age you began your menses? ____________________

Frequency of Periods? ☐*Every 28 days* ☐*Other* ____________________

Duration of menstrual cycle? ____________________

Level of bleeding during menstrual cycle? ☐ *light* ☐*medium* ☐*heavy*

Unusual or missed periods in the last year? ____________________

During your menses, do you experience cramping? *Premenstrual?* ☐*Yes* ☐*No* *Severe?* ☐*Yes* ☐*No*

What medications do you use if any to relieve cramping? ____________________

MISCELLANEOUS QUESTIONS: *Thank you for providing us the above information. Please list below any information that is significant or that you feel we may need to know.*

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