

Date: \_\_\_\_\_

**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:** \_\_\_\_\_ **DOB:** \_\_\_\_\_

**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? \_\_\_\_\_

Age of first menstrual cycle? \_\_\_\_\_ On Birth Control at Conception? \_\_\_\_\_

Date of your pregnancy test? \_\_\_\_\_ Was it urine? \_\_\_\_\_

**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	<b>Other:</b>		

**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 PIV	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

Patient Name: \_\_\_\_\_

**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: \_\_\_\_\_

\_\_\_\_\_

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

\_\_\_\_\_

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

Date: \_\_\_\_\_

**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).*

\_\_\_\_\_  
\_\_\_\_\_

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**

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

Patient Name: \_\_\_\_\_

**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.

How did you learn of our practice? \_\_\_\_\_

**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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