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OB PATIENT QUESTIONNAIRE

Patient Name_____Today's Date ____/_____/_____

Date of Birth ___/___/_____ Age _____ Ethnicity_____ Martial Status ☐Single |☐Married |☐Living with Partner

Address _____

Home Phone_____ Work Phone_____ Cell phone_____

Place of Emplyoment/Occupation_____

Emergency Contact: Home_____ Work_____ Cell_____

Father of Baby _____ Involved with Pregnancy? Y ☐ | N☐ Date of Birth ___/___/_____ Age ____

Father's Occupation_____ Work_____ Cell _____

MEDICAL HISTORY

PAST MEDICAL HISTORY	

PAST SURGICAL HISTORY (YEAR & EXPLAIN)

MEDICATIONS (LIST ALL MEDICATIONS/SUPPLEMETS YOU ARE CURRENTLY TAKING)	DRUG ALLERGIES & REACTION

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

PAP Last test_____/_____/_____ **Ever had an abnormal result?** Y☐ N☐ **Colposcopy** Y☐ N☐ **Cryo/LEEP** Y☐ N☐

CONTRACEPTIVE HISTORY Current/Previous Method _____

OBSTETRICAL HISTORY # of Pregnancies _____ Premature Babies _____ Miscarriages_____ Abortions _____ Living Children_____

DATE	#WEEKS	WEIGHT	SEX	TYPE OF DELIVERY	COMPLICATIONS WITH PREGNANCY	COMPLICATIONS WITH DELIVERY
1.						
2.						
3.						
4.						
5.						
6.						

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Patient Name: _____

RISK FACTORS FOR PREGNANCY

List any over-the-counter medications used since your last period:

List any prescriptions medications used since your last period:

Have you had any X-rays since your last period?	Y ☐	N ☐	Explain:
Do you have contact with cat litter (feces) or eat raw or uncooked meats?	Y ☐	N ☐	
Have you ever experimented with marijuana, cocaine, or other illicit drugs?	Y ☐	N ☐	
Have you been exposed to marijuana, cocaine, or other illicit drugs since your last period?	Y ☐	N ☐	

PAST MEDICAL & FAMILY HISTORY (PLEASE CHECK √ IF YOU (SELF) OR ANY BLOOD RELATIVE (FAM) HAVE ANY OF THE FOLLOWING):

	SELF	FAM	EXPLAIN		SELF	FAM	EXPLAIN
Headaches	☐	☐		Blood transfusions	☐	☐	
Heart/Vascular disease	☐	☐		Anemia/Blood disorder	☐	☐	
Rheumatic disease	☐	☐		Stroke	☐	☐	
High Blood Pressure	☐	☐		DVT/ Pulmonary Embolism	☐	☐	
High Cholesterol	☐	☐		Skin disease	☐	☐	
Respiratory disease	☐	☐		Diabetes	☐	☐	
Pulmonary /asthma	☐	☐		Thyroid disease	☐	☐	
Breast Cancer	☐	☐		Cancer (type)	☐	☐	
Jaundice/Hepatitis	☐	☐		Uterine or Ovarian Cancer	☐	☐	
Reflux/Ulcer	☐	☐		Epilepsy/Neurologic disease	☐	☐	
Bowel disease/Colon Cancer	☐	☐		Arthritis – Joint pain	☐	☐	
Kidney disease	☐	☐		Osteoporosis/Joint Problems	☐	☐	
Urinary Incontinence	☐	☐		Anxiety/Depression	☐	☐	
Urinary Infections	☐	☐		Sleep Problems	☐	☐	
STD	☐	Partner? ☐		Genital Herpes	☐	Partner? ☐	

VACCINES: COVID-19 ☐ | Chicken Pox ☐ |Childhood Vaccines ☐ | HPV ☐ | Hepatitis A ☐ | Hepatitis B ☐| Last Tetanus: _____

SOCIAL HISTORY: Smoking – Cig./Day _____ # Years _____ Alcohol – Oz/Week _____ Caffeine – Cup/Day_____

GENETIC AND INFECTION SCREENING:

	Y	N		Y	N
Patient's Age Will Be 35 Or Older at EDD			Maternal Metabolic Disorder (e.g. Type 1 Diabetes, PKU)		
Thalassemia (Italian, Greek, or Asian Background): MCV <80			Patient or Baby's Father Has a Child with Birth Defects		
Neural Tube Defect (e.g. Spina Bifida/Anencephaly)			Recurrent Pregnancy Loss, or A Stillbirth		
Congenital Heart Defect			Medications (see list on 1st page)		
Down Syndrome			If Yes, Agent(s) And Strength/Dosage (see list on 1st page)		
Tay-Sachs (e.g. Jewish, Cajun, French-Canadian)			Any Other Genetic History		
Canavan Disease			Live With Someone with TB or Exposed to TB		
Sickle Cell Disease or Trait (African)			Patient or Partner Has History of Genital Herpes		
Hemophilia or Other Blood Disorders			Rash or Viral Illness Since Last Menstrual Period		
Muscular Dystrophy			History of STD, Gonorrhea, Chlamydia, HPV, Syphilis		
Cystic Fibrosis			Other Infection History		
Huntington's Chorea			History of HIV		
Intellectual Disability/Autism			History of Hepatitis		
If Yes, was person Tested for Fragile X?			Prior GBS-infected child		
Other Inherited Genetic or Chromosomal Disorder					

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 ☐

IS THERE ANYTHING GENETIC YOU ARE CONCERNED ABOUT? Y ☐ N ☐ Explain:

IF YOU ARE BLOOD rH NEGATIVE, DID YOU RECEIVE Rhogam AFTER EACH PREGNANCY (include miscarriages and abortions)**?** Y ☐ N ☐

Thank you! We will see you soon!