OBSTETRICAL QUESTIONNAIRE

Date: _____ Patient Name: _____

D.O.B.: _____ Age: _____

Chief Complaint: _____

Primary Language: _____ Education: _____ Baby's Father: _____

Language at Home: _____ Hazards: _____ Father's Phone: (___) ___-____

Birthplace: _____ _____ Support Person: _____

Mother's Ethnicity: _____ Religion: _____ Support Phone: (___) ___-____

Marital Status: _____ Baby's Father's Ethnicity: _____

Pediatrician: _____

Prenatal Classes: O yes O no

Feeding: O breast O bottle O both

Does patient agree to transfusion?: O yes O no

Desires sterilization: O yes O no

Lifestyle

Activity Level: _____ Health Club Member: O now O previously O never

Exercise Frequency: _____ Type of Exercise: _____

Hobbies/activities: _____ _____ _____

Diet History: _____ _____ _____ _____ _____

Safety

Firearms in home: O yes O no Smoke detectors in home: O yes O no

Seat belt use: O yes O no Carbon monoxide detectors in home: O yes O no

☐ **Cats in home** Radon in home: O yes O no O treated O untested

Comments

_____

_____

ALLERGIES

[ ] No Known Drug Allergies

Allergy	Reaction

OBSTETRICAL QUESTIONNAIRE

MEDICATIONS

[ ] No Medications

Brand/Generic Name	Prescribing Physician	Start Date	Dosage/How Often

ADDITIONAL MEDICATIONS – Attach List

PAST OBSTETRICAL HISTORY

Number of: Full Term: _____ Preterm: _____ C-Section: _____ Vaginal: _____ Live Births: _____
Live at Present: _____ Ectopic: _____ Miscarriages: _____ Abortions: _____

#	Date	Sex (M/F)	Weight (lbs.-oz.)	Pregnancy Duration (weeks)	Duration of Labor	Type of Delivery	Anesthesia? (circle one)		Complications
							Yes	No	
							Yes	No	
							Yes	No	
							Yes	No	

GYNOCOLOGICAL HISTORY

Last Menstrual Period: _____ **Last Pap Smear:** _____ **Last Mammogram:** _____
Age began Menstruation: _____ **Cycle Frequency:** _____ **Duration** (# of days): _____
Type of Birth Control: _____

MEDICAL HISTORY

Disease	(circle one)		Disease	(circle one)	
Diabetes	Yes	No	**Varicella** (chicken pox)	Yes	No
Hypertension	Yes	No	**Pulmonary Problems** (TB,Asthma)	Yes	No
Heart Disease	Yes	No	**Seasonal Allergies**	Yes	No
Autoimmune Disorder	Yes	No	**Drug / Latex Allergies**	Yes	No
Kidney Disease / UTI	Yes	No	**Breast Problems**	Yes	No
Neurologic / Epilepsy	Yes	No	**GYN Surgery** (list below)	Yes	No
Psychiatric	Yes	No	**Other Operations** (list below)	Yes	No
Depression / Postpartum	Yes	No	**Anesthetic Complications**	Yes	No
Hepatitis / Liver Disease	Yes	No	**History of Abnormal PAP**	Yes	No
Varicosities / Phlebitis	Yes	No	**Uterine Anomaly**	Yes	No
Thyroid Dysfunction	Yes	No	**Infertility**	Yes	No
Trauma/Violence	Yes	No	**Assisted Reproductive Technology**	Yes	No
Blood Transfusions	Yes	No	**Relevant History**	Yes	No
D (Rh) Sensitive	Yes	No	**Cats as Pets** (cat litter)	Yes	No

SOCIAL HISTORY	Type	Pre-pregnancy amount/packs per day	Pregnant amount/packs per day	Number of Years Used
Tobacco				
Alcohol				
Caffeine				
Recreational Drugs				

INFECTION HISTORY

1) Live with someone with TB or exposed to TB (tuberculosis) **Yes** **No**
2) Patient or Partner has history of genital herpes (CIRCLE: **Patient / Partner**) **Yes** **No**
3) Rash or viral illness since last menstrual period **Yes** **No**
4) Hepatitis-B or Hepatitis-C (circle which type) **Yes** **No**
5) History of the following (below, circle all that apply):

HPV **Gonorrhea** **HIV** **Chlamydia** **Syphilis**

PAST MEDICAL HISTORY

Disease	Date

PAST SURGICAL HISTORY

Description	Date

FAMILY MEDICAL HISTORY

Disease	Family Member

OBSTETRICAL QUESTIONNAIRE

GENETIC COUNSELING / TERATOLOGY COUNSELING

Patient Name: _____ Date: _____

Father of Baby Name: _____ Phone Number: (___) ___-_____

1. Patient's age 36 years or older as of estimated date of delivery	**Yes**	**No**
2. Thalassemia (Italian, Greek, Mediterranean, or Asian background)	**Yes**	**No**
3. Neural Tube Defects (meningomyelocele, spina bifida of anencephaly)	**Yes**	**No**
4. Congenital heart defect	**Yes**	**No**
5. Down Syndrome	**Yes**	**No**
6. Tay Sachs (Ashkenazi Jewish, Cajun, French Canadian)	**Yes**	**No**
7. Canavan Disease (Ashkenazi Jewish)	**Yes**	**No**
8. Familial dysautonomia (Ashkenazi Jewish)	**Yes**	**No**
9. Sickle Cell disease or trait (African)	**Yes**	**No**
10. Hemophilia or other blood disorders	**Yes**	**No**
11. Muscular dystrophy	**Yes**	**No**
12. Cystic fibrosis	**Yes**	**No**
13. Huntington's chorea	**Yes**	**No**
14. Mental Retardation / autism	**Yes**	**No**
15. Other inherited genetic or chromosomal disorder	**Yes**	**No**
16. Maternal metabolic disorder (e.g.: Type 1 Diabetes, PKU)	**Yes**	**No**
17. Patient or baby's father had a child with birth defects not listed above	**Yes**	**No**
18. Recurrent pregnancy loss or stillbirth	**Yes**	**No**
19. Medications (including supplements, vitamins, herbs, or OTC drugs / illicit / recreational drugs / alcohol since Last Menstrual Period)	**Yes**	**No**

If YES, list agent and strength / dosage :

_____

_____

_____