OBSTETRIX MEDICAL GROUP

Patient Name: _____ DOB: _____

Social Security Number: _____ Today's Date: _____

Obstetric History Questionnaire

Are you currently pregnant? ☐ Yes ☐ No

What was the first day of your last menstrual period: _____

What is your due date: _____ What is your blood type? _____

Are there any problems with your current pregnancy:

_____

_____

_____

Prior Pregnancies:

_____ Number of total pregnancies

_____ Number of pregnancies carried to full term (40 weeks)

_____ Number of pregnancies delivered prematurely

_____ Number of pregnancies continued past 4 ½ months (20 weeks)

_____ Number of miscarriages (spontaneous)

_____ Number of tubal pregnancies (ectopic pregnancies)

_____ Number of voluntary abortions

_____ Number of multiple births

_____ Number of living children

Fill information in table below for each pregnancy (living or deceased) start with your first one:

Year	Weeks (Full term = 40 wks.)	Labor Length	Birth Wt LB. / OZ.	Sex	Type Of Delivery (Vaginal or Cesarean Section)	Anesthesia	Place

Comments: _____

_____

_____

Have you had a sonogram / ultrasound during the current pregnancy? ☐ Yes ☐ No

Do you wish to know the sex of the baby? ☐ Yes ☐ No

Genetic / Family History Questionnaire

How would you describe your ancestry (check all that apply):

☐ Caucasian (White)	☐ French Canadian	☐ Asian
☐ African (Black)	☐ Native American	☐ Asian-East Indian
☐ Hispanic	☐ Mediterranean	☐ Other Southeast Asian
☐ Ashkenazi Jewish	☐ Middle Eastern	☐ Unknown Race
☐ Cajun		☐ Other _____

Are you and the father of this baby blood relatives (example: cousins)? ☐ Yes ☐ No

What is your occupation? _____

What is the name of the father of this baby? _____

What is the occupation of the father of this baby? _____

What is the age of the father of this baby? _____

How would you describe the ancestry of the father of this baby (check all that apply):

☐ Caucasian (White)	☐ French Canadian	☐ Asian
☐ African (Black)	☐ Native American	☐ Asian-East Indian
☐ Hispanic	☐ Mediterranean	☐ Other Southeast Asian
☐ Ashkenazi Jewish	☐ Middle Eastern	☐ Unknown Race
☐ Cajun		☐ Other _____

Is the father of this baby your partner? ☐ Yes ☐ No

Comments: _____

_____

_____

Do you, the father of this baby, or any close relatives have:
If yes, please specify which relative…….

1. Thalassemia MCV < 80	☐ Yes	☐ No
2. Neural Tube Defect (Spina Bifida, or Anencephaly)	☐ Yes	☐ No
3. Congenital Heart Defect	☐ Yes	☐ No
4. Down Syndrome	☐ Yes	☐ No

5. Tay-Sachs ☐ Yes ☐ No
6. Sickle Cell Disease or Trait ☐ Yes ☐ No
7. Hemophilia or Bleeding Problems (Type: _____) ☐ Yes ☐ No
8. Muscular Dystrophy (Type: _____) ☐ Yes ☐ No
9. Cystic Fibrosis ☐ Yes ☐ No
10. Canavan Disease ☐ Yes ☐ No
11. Mental Retardation / Autism / Learning Disorder ☐ Yes ☐ No

    If Yes: Tested for Fragile X ☐ Yes ☐ No
12. Huntington Chorea ☐ Yes ☐ No
13. Other Inherited Genetic or Chromosomal Disorder (Type: _____) ☐ Yes ☐ No
14. Maternal Metabolic Disorder (i.e. Insulin-Dependent Diabetes, PKU) (Type: _____) ☐ Yes ☐ No
15. Patient or Baby's Father Had a Child With Birth Defects Not Listed Above (Type: _____) ☐ Yes ☐ No
16. Recurrent Pregnancy Loss, or Stillbirth ☐ Yes ☐ No
17. Blindness or Deafness ☐ Yes ☐ No
18. Bone or Skeletal Disorder (Dwarfism) (Type: _____) ☐ Yes ☐ No
19. Breast, Ovarian or Colon Cancer ☐ Yes ☐ No
20. Kidney Disorder (Type: _____) ☐ Yes ☐ No
21. Diabetes ☐ Yes ☐ No
22. Blood Clots or Stroke ☐ Yes ☐ No
23. Have you taken any medications other than PN vitamins since becoming pregnant ☐ Yes ☐ No

    If Yes, what type: _____
24. Have you used any street drugs since becoming pregnant ☐ Yes ☐ No

    If Yes, what type: _____
25. Have you consumed any alcoholic beverages since becoming pregnant ☐ Yes ☐ No

    If Yes, how much and how often:

    _____
26. Any Other Illnesses: (Type: _____) ☐ Yes ☐ No
27. Anything else that seems to run in the family (Type: _____) ☐ Yes ☐ No

Comments: _____

_____

_____

Have you had exposure to:

Sauna ☐ Yes ☐ No Cat Litter ☐ Yes ☐ No X-rays ☐ Yes ☐ No

Hot tub ☐ Yes ☐ No Chemicals ☐ Yes ☐ No Fever / Infections / Rashes ☐ Yes ☐ No

Electric blanket ☐ Yes ☐ No Do you smoke? ☐ Yes ☐ No

Review Of Systems Questionnaire

Do you or have you taken any medication in the last year:

Medications Taken	Date Taken

Do you have any known allergies:

Are you allergic to any drugs / medications? Specify

_____

_____

Do you have or have you had any of the following conditions:

☐ Yes	☐ No	☐ Unsure	Unexplained Fever
☐ Yes	☐ No	☐ Unsure	Vision Problems
☐ Yes	☐ No	☐ Unsure	Hearing Loss
☐ Yes	☐ No	☐ Unsure	Ear Infections (Other Than Childhood)
☐ Yes	☐ No	☐ Unsure	Sinus Problems
☐ Yes	☐ No	☐ Unsure	Repeated Nosebleeds
☐ Yes	☐ No	☐ Unsure	Long Term Sore Throat
☐ Yes	☐ No	☐ Unsure	Pneumonia
☐ Yes	☐ No	☐ Unsure	Asthma
☐ Yes	☐ No	☐ Unsure	Close Contact With Person(s) With Tuberculosis
☐ Yes	☐ No	☐ Unsure	Tuberculosis Vaccine (BCC)
☐ Yes	☐ No	☐ Unsure	Positive Tuberculosis Skin Test
☐ Yes	☐ No	☐ Unsure	Unexplained Cough
☐ Yes	☐ No	☐ Unsure	Unexplained Shortness Of Breath
☐ Yes	☐ No	☐ Unsure	Other Lung Problems
☐ Yes	☐ No	☐ Unsure	Heart Murmur
☐ Yes	☐ No	☐ Unsure	Mitral Valve Prolapse
☐ Yes	☐ No	☐ Unsure	Other Heart Problems
☐ Yes	☐ No	☐ Unsure	High Blood Pressure in Pregnancy
☐ Yes	☐ No	☐ Unsure	High Blood Pressure, Other
☐ Yes	☐ No	☐ Unsure	Raynaud's Disease, Raynaud's Phenomenon
☐ Yes	☐ No	☐ Unsure	Poor Blood Circulation
☐ Yes	☐ No	☐ Unsure	Severe Nausea And Vomiting In Pregnancy
☐ Yes	☐ No	☐ Unsure	Severe Nausea And Vomiting Before Pregnancy

☐ Yes	☐ No	☐ Unsure	Intestinal Problems (Irritable Colon, Crohn's Disease, etc.)
☐ Yes	☐ No	☐ Unsure	Unexplained Recurring Diarrhea
☐ Yes	☐ No	☐ Unsure	Constipation Problem
☐ Yes	☐ No	☐ Unsure	Heartburn, Reflux
☐ Yes	☐ No	☐ Unsure	Hepatitis, Yellow Jaundice
☐ Yes	☐ No	☐ Unsure	Liver Problems
☐ Yes	☐ No	☐ Unsure	Bladder or Kidney Infections
☐ Yes	☐ No	☐ Unsure	Kidney Stones
☐ Yes	☐ No	☐ Unsure	Problems With Urine
☐ Yes	☐ No	☐ Unsure	Menstrual Problems
☐ Yes	☐ No	☐ Unsure	Infertility, Difficulty Getting Pregnant
☐ Yes	☐ No	☐ Unsure	Vaginal Infections
☐ Yes	☐ No	☐ Unsure	Herpes Or A Partner With Herpes
☐ Yes	☐ No	☐ Unsure	Sexually Transmitted Disease
☐ Yes	☐ No	☐ Unsure	Pelvic Inflammatory Disease
☐ Yes	☐ No	☐ Unsure	Gonorrhea
☐ Yes	☐ No	☐ Unsure	Chlamydia
☐ Yes	☐ No	☐ Unsure	Syphilis
☐ Yes	☐ No	☐ Unsure	Genital Warts
☐ Yes	☐ No	☐ Unsure	HIV Infection, AIDS Or A Partner With HIV / AIDS
☐ Yes	☐ No	☐ Unsure	Abnormal Pap Smears
☐ Yes	☐ No	☐ Unsure	Diabetes (High Blood Sugar)
☐ Yes	☐ No	☐ Unsure	Thyroid Problems
☐ Yes	☐ No	☐ Unsure	Other Hormone Problems
☐ Yes	☐ No	☐ Unsure	Epilepsy, Seizure Disorder
☐ Yes	☐ No	☐ Unsure	Unexplained Drowsiness
☐ Yes	☐ No	☐ Unsure	Migraine / Cluster Headaches
☐ Yes	☐ No	☐ Unsure	Other Recurring Headaches
☐ Yes	☐ No	☐ Unsure	Depression
☐ Yes	☐ No	☐ Unsure	Panic Attack Disorder
☐ Yes	☐ No	☐ Unsure	Mood Disorder / Psychiatric / Emotional Problems
☐ Yes	☐ No	☐ Unsure	Skin Problems
☐ Yes	☐ No	☐ Unsure	Unexplained Hair Loss
☐ Yes	☐ No	☐ Unsure	Arthritis / Joint Pains
☐ Yes	☐ No	☐ Unsure	Lupus
☐ Yes	☐ No	☐ Unsure	Rheumatic Fever
☐ Yes	☐ No	☐ Unsure	Blood Transfusions
☐ Yes	☐ No	☐ Unsure	Bleeding Tendency
☐ Yes	☐ No	☐ Unsure	Blood Clots, Thrombophlebitis
☐ Yes	☐ No	☐ Unsure	Rh Sensitized

Reviewed By: _____

Provider Name