OB Questionnaire

Date: _____ **Name:**_____ **DOB:** _____

Religion: _____ **Insurance Type:** _____

Height:_____ **Weight:** _____ **Employer:** _____

Education Completed:_____ **Primary Care Doctor:**_____

Marital Status: Single Married Widowed Divorced Separated

Your own medical history:

Age when period started? _____ How long attempted pregnancy?_____

When was your last pap smear? _____ How much did you weigh at birth? _____

^^What were the results? _____ How often do periods come?_____

How long does your period last?_____ Is it light/normal/heavy?_____

When was your last period?_____ Was your last period normal?_____

Have you had any surgeries? Please list type and dates: _____

_____

Do you have a history of depression, headaches, or nervous disorders? Yes / No

Have you ever had a blood transfusion, if yes - when?_____

Have you had Chicken Pox? Yes / No Have you had the Chicken Pox vaccine? Yes / No

Do you currently smoke? Yes / No How many packs per day?_____

Do you currently drink alcohol? Yes / No How often per week? _____

Do you currently use any recreational drugs? Yes / No

Do you have/have you had any Sexually Transmitted Diseases (STD's), describe?_____

_____

Father of Child:

Name: _____ Phone #:_____

Height:_____ Weight:_____ Age:_____ Is he in good health? Yes / No

Genetic Screening:

***Please address the following if they have affected you, your baby's father, or immediate family (i.e. mother, father, brother, or sister ONLY)**

Condition	Yes	No	Unknown
Huntington's Chorea?			
Mental Retardation/Autism?			
Neural tube defect (anencephaly, spina bifida, etc.)?			
Congenital heart defect?			
Other inherited genetic/chromosomal disorder?			
Down Syndrome?			
MATERNAL Diabetes/PKU?			
Patient/Father of baby have another child with birth defects not listed above?			
Canavan Disease?			
Recurrent pregnancy loss/Stillbirth?			
Familial Dysautonomia?			
Sickle Cell Disease or Trait?			
Hemophilia or other blood disorder			
Muscular dystrophy?			
Cystic fibrosis?			

Family medical history:

***Please address the following if they have affected you, your baby's father, your children, or other immediate family (i.e. mother, father, brother, or sister ONLY).**

Diabetes:_____
High Blood Pressure:_____
Heart Disease:_____
Autoimmune Disorder:_____
Kidney Disease:_____
Epilepsy:_____
Psychiatric Disorders:_____
Depression/Postpartum Depression:_____
Liver Disease/Hepatitis: _____
Varicose Veins:_____
Thyroid Disorder:_____

Blood Antibody Reaction:_____
Lung Disease/TB/Asthma:_____
Seasonal Allergies:_____
Breast Disease:_____
Uterine Abnormality:_____
Infertility:_____
IVF/Artificial Insemination:_____
Blood/Bone Disease:_____
Cancer:_____
Drug Allergy:_____
Other Allergy:_____

Birth Defects/Conditions (i.e. cystic fibrosis, muscular dystrophy, etc):_____

Current Pregnancy:

***Please circle all that you have experienced during THIS pregnancy:**

Nausea Frequent Urination Vomiting Bleeding Indigestion Constipation
Vaginal Discharge Itching Headaches Motor Vehicle Accident Dizziness
German Measles Eye Sight Problems Viral Infection Swelling Stomach Pain
Burning or stinging with urination X-Ray Taking a medication Changed a medication

Past Pregnancy(ies):

***Please include ALL pregnancies, miscarriages, still births, etc.**

Date (Month/Year)	How many weeks were you when you delivered?	Length of labor	Birth weight	Sex (M/F)	How did you deliver? (vaginal/ c-section)	Were you given an epidural or anesthesia?	Place of delivery

Did you have any problems with previous pregnancies or deliveries (please list in detail)? _____
_____
_____