Pt Name:_____

MRN:_____

NEW OB PATIENT QUESTIONNAIRE

PATIENT NAME: _____ DOB: _____TODAY'S DATE: _____

Height: _____ How much did you weigh **before** you were pregnant? Pre-Pregnancy Weight: _____
Was your last period normal? _____ Are you certain about the date? _____
What Birth Control, if any, were you on at Conception? _____
Date of your pregnancy test? _____ Was it urine? _____
Any travel in the last 6 months for you or your partner? Please specify Where/When for each of you: **YES NO**
_____

PERSONAL MEDICAL HISTORY: Did you or do you presently have any of the following, please circle **YES** or **NO**

Anemia	**YES**	**NO**	History of Blood Transfusion	**YES**	**NO**
Anemia in Pregnancy	**YES**	**NO**	History of Sexually Transmitted Disease	**YES**	**NO**
Anesthetic Complications	**YES**	**NO**	High Blood pressure/Hypertension	**YES**	**NO**
Asthma	**YES**	**NO**	Hypertension in Pregnancy	**YES**	**NO**
Bleeding Disorder	**YES**	**NO**	Infertility	**YES**	**NO**
Breast Disease	**YES**	**NO**	Kidney disease	**YES**	**NO**
Cancer (specify)	**YES**	**NO**	Liver disease	**YES**	**NO**
Chicken Pox or Immunization	**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 yearly)	**YES**	**NO**
Diabetes Type I	**YES**	**NO**	Skin Disorder	**YES**	**NO**
Diabetes Type II	**YES**	**NO**	Tuberculosis	**YES**	**NO**
Diabetes in Pregnancy	**YES**	**NO**	Thrombophlebitis/Embolism/DVT	**YES**	**NO**
Epilepsy	**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**

INFECTION HISTORY: Please circle YES or NO to any of the following:

Exposed to Tuberculosis	**YES**	**NO**	History of HPV Warts _____ Pap _____	**YES**	**NO**
History of Chlamydia	**YES**	**NO**	History of PID	**YES**	**NO**
History of Genital Herpes	**YES**	**NO**	History of Syphilis	**YES**	**NO**
History of Gonorrhea	**YES**	**NO**	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**

PAST SURGICAL HISTORY: Please list and date any past surgeries (including tonsillectomy).
_____
_____
Any personal or family problems with anesthesia? If yes, specify _____

Have you ever had surgery done on your uterus? If yes, when? _____
Have you had an Abnormal Pap? If so, have you had a Colposcopy, LEEP or Cone Biopsy? **YES NO**
If yes, what and when? _____

BLOOD TRANSFUSION IN THE PAST? YES NO
Is a blood transfusion acceptable? YES NO
Do you have any religious beliefs that would conflict with the need for a blood transfusion? YES NO

HOSPITALIZATIONS: Have you ever been hospitalized (not including childbirth or surgery)? **YES NO**
If yes, for what and when?_____

ALLERGIES/DRUG ALLERGIES: NONE ____ Latex: YES NO
Please list and include reactions _____

MEDICATIONS: Please list any medications you are presently taking or that you have taken since your last menstrual period or first positive pregnancy test (List **dose and frequency** and attach a list if necessary).

1.	**6.**
2.	**7.**
3.	**8.**
4.	**9.**
5.	**10.**

FAMILY MEDICAL HISTORY: Please circle YES or NO to the following questions about **your family's history and the Father of the baby's personal or family history**. (This should include Uncles, Aunts, Grandparents, Cousins, etc.)

Your Family History			**Father of the Baby's Personal or Family History**	
YES	**NO**	Blood Disorder/Hemophilia	**YES**	**NO**
YES	**NO**	Chromosomal Anomaly/Disorder	**YES**	**NO**
YES	**NO**	Congenital Heart Defect	**YES**	**NO**
YES	**NO**	Cystic Fibrosis	**YES**	**NO**
YES	**NO**	Down Syndrome	**YES**	**NO**
YES	**NO**	Endocrine Disorder/Maternal Metabolic Disorders	**YES**	**NO**
YES	**NO**	Huntington's Disease/Huntington Chorea	**YES**	**NO**
YES	**NO**	Mental Retardation	**YES**	**NO**
YES	**NO**	Muscular Dystrophy	**YES**	**NO**
YES	**NO**	Neural Tube Defect (including "water in the brain" or Spina Bifida)	**YES**	**NO**
YES	**NO**	Sickle Cell Disease	**YES**	**NO**
YES	**NO**	Sickle Cell Trait	**YES**	**NO**
YES	**NO**	SMA (Spinal Muscular Atrophy)	**YES**	**NO**
YES	**NO**	Tay-Sachs Disease	**YES**	**NO**
YES	**NO**	Thalassemia	**YES**	**NO**

PERSONAL HABITS/SOCIAL HISTORY: Please check or circle your answer.
Marital Status: Single__ Engaged__ Married__ Widowed__ Separated__ Divorced__ Living w/ 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 and how much? _____
Do you live with a cat? YES NO If yes, do you handle the cat feces? 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
Do you have any religious preference? **YES NO** If yes, please specify_____

PRGENANCY/BIRTH HISTORY

Father of the baby: _____ His phone number: _____
What is his race? White Black Hispanic Arabic Asian Ashkenazi Jewish Heritage Other: _____
What is your race? White Black Hispanic Arabic Asian Other: _____
Do you have any Ashkenazi Jewish or French Canadian Heritage? _____
Total Number of Pregnancies (including this one):___ Deliveries (Para)__ Ectopic __ Abortion __ Miscarriage ____

Using the chart below, please list all pregnancies in order. Circle when applicable.

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					
		Y / N		M / F					

Please use the back of this sheet if you need more space.

Please answer only if you have been pregnant previously: **N/A**

Have you ever had preterm labor (before 36 weeks)?	**YES**	**NO**
Has your water ruptured before 36 weeks?	**YES**	**NO**
Has your cervix been dilated before 36 weeks?	**YES**	**NO**
Have you had any prior C-Sections?	**YES**	**NO**
Have you ever needed a D&C after a baby was born?	**YES**	**NO**
Have you ever had a placenta abruption or placenta previa?	**YES**	**NO**
Have you had a baby require treatment for Group Beta Strep after delivery?	**YES**	**NO**
Have you had a baby with a birth defect?	**YES**	**NO**
Have you had a still birth?	**YES**	**NO**

How did you learn about 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. _____
_____
_____
_____
_____
_____