# Obstetric History Questionnaire

***Patient Name:*** _____ ***Date of Birth:*** _____ ***Date:*** _____

**Are you currently pregnant:** ☐ Yes ☐ No (If No, please skip to Drug Allergy Box Below**)

**Are there any problems with your current pregnancy?** _____

**Height:**_____ **Pre-pregnancy weight:**_____ **Pharmacy Name**_____ **#(____)**_____

**What was the first day of your last menstrual period:** _____**Definite date or Unknown date**

**What is your due date:** _____ **Preferred language:**_____

**Do you smoke cigarettes? ☐ No ☐ Yes→ Number of packs per day:**_____ **Have you quit previously?**_____

**Do you drink alcoholic beverages? ☐ No ☐ Yes→Number of drinks per week:**_____

**Do you use any recreational drugs? ☐ No ☐ Yes→Which one(s)?**_____

**What is your occupation?** _____

**Is this pregnancy a result of fertility treatments?** ☐ No ☐ Yes **What type?**_____**Donor egg? Y/ N Age of egg/donor?** _____

**Which fertility practice followed you?** _____ **If IVF, fertilization date:**_____

**Have you had any blood work to determine the baby's gender?** ☐ No ☐ Yes**: Results:**_____

**What <u>other</u> genetic testing have you had?** (Down syndrome screening? Cystic Fibrosis? AFP? Quad screen?)

_____

****Do you have any known allergies to any drugs? No ☐ If yes, please list drug and reaction:**

| |
|---|
| ***Example: Penicillin- hives and rash*** |
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## MEDICAL HISTORY:

**PLEASE LIST ANY CHRONIC MEDICAL PROBLEMS YOU CURRENTLY HAVE OR HAD IN THE PAST:**

***Example: Any ER visits? Being worked up by provider for a health problem? Any illness that you took long term medication for?***

**1.**_____ **4.**_____ **7.**_____ **10.** _____
**2.**_____ **5.**_____ **8.**_____ **11.** _____
**3.**_____ **6.**_____ **9.**_____ **12.**_____

**HAVE YOU EVER BEEN IN THE HOSPITAL OR HAD ANY SURGERY:**

| SURGERY | Reason | Date | HOSPITALIZATION | Reason | DATE |
|---|---|---|---|---|---|
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**REVIEW OF SYSTEMS: PLEASE CHECK ANY CURRENT SYMPTOMS:**

| | |
|---|---|
| **Constitutional** | □ Night sweats □ Fever □ Unexplained weight loss □ Recent trauma |
| **Eyes** | □ Visual changes □ Double vision □ Blind spots □ Floaters □ Redness □ Glasses/contacts |
| **ENT** | □ Nose bleeds □ Ringing in ears □ Sore throat □ Difficulty swallowing □ Ear pain □ Tooth pain □ Gum bleeding |
| **Cardiovascular** | □ Chest pain □ Shortness of breath □ Swelling □ Palpitations □ Fainting □ Loss of consciousness |
| **Respiratory** | □ Cough □ Sputum □ Wheezing □ Coughing up blood □ Shortness of breath □ Exercise intolerance |
| **GI** | □ Abdominal pain □ Change in appetite □ Difficulty swallowing □ Heartburn □ Vomiting □ Blood in stool □ Diarrhea □ Constipation |
| **GU** | □ Difficulty urinating □ Pain with urination □ Blood in urine □ Incontinence □ Vaginal bleeding □ Vaginal discharge □ Pelvic pain □ Breast pain □ Breast lumps |
| **Musculoskeletal** | □ Joint pain □ Joint swelling □ Decreased range of motion □ Back pain □ Loss of movement |
| **Skin** | □ Itching □ Rash □ Non-healing wound □ Nodule □ Excessive dryness □ Change in skin color |
| **Neurological** | □ Headache □ Weakness □ Seizures □ Head trauma □ Loss of consciousness □ Dizziness □ Confusion □ Tremor □ Difficulty walking □ Memory loss □ Change in sight, smell, hearing or taste □ Numbness |
| **Psychiatric** | □ Anxiety □ Depression □ Panic □ Excessive sadness □ Tearfulness □ Thoughts of suicide □ Paranoia |
| **Endocrine** | □ Mood swings □ Excessive sweating □ Irregular periods □ Hot or Cold intolerance |
| **Hematologic** | □ Bruising □ Excessive bleeding □ History of blood transfusion |
| **Sleep** | □ Snoring □ Apnea |

**Please list any complications during your previous pregnancies:**

□ High blood pressure □ Diabetes □ Short cervix/cerclage □ Stillbirth
□ Depression □ Blood clot □ IUGR/small baby □ Macrosomia/large baby

□ Long term hospitalization during the pregnancy: Why?_____
□ Other specific complications: _____

**Fill information in table below for <u>each</u> pregnancy, include <u>miscarriages and abortions</u>**
**Please start with your first one:**

| Date of Birth | Weeks | Labor Length | Birth Wt LB. / OZ. | Sex | Type Of Delivery | Type of Anesthesia | Hospital/ Location | Complications |
|---|---|---|---|---|---|---|---|---|
| ***Ex: 2/2/2008*** | ***38*** | ***14 hrs*** | ***6lbs8oz*** | ***M*** | ***Vaginal or CSection*** | ***Epidural*** | ***Northside, GA, GA*** | ***Diabetes, low amniotic fluid*** |
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| # Total Pregnancies | # Full Term | # Premature (<37 wks) | #Miscarriages | # Abortions | # Ectopics | #Multiple Births | # Living Children |
|---|---|---|---|---|---|---|---|
| | | | | | | | |

**Are you and the baby's father related in any way (ie cousins)? ☐ No ☐ Yes→ Relationship:_____**

**In your family, are there any ancestors who are:**

☐ **French Canadian** ☐ **Cajun** ☐ **Ashkenazi Jewish** ☐ **Africa** ☐ **Asia** ☐ **Mediterranean**

**If YES, explain: _____**

**In the family of the father of this baby, are there any ancestors who are:**

☐ **French Canadian** ☐ **Cajun** ☐ **Ashkenazi Jewish** ☐ **Africa** ☐ **Asia** ☐ **Mediterranean**

**If YES, explain: _____**

**Do you, the father of this baby, or any close relatives have: If yes, explain in comment section and the relationship:**

| | | |
|---|---|---|
| 1.Neural Tube Defect (ie Meningomyelocele, Spina Bifida, or Anencephaly) | ☐ Yes | ☐ No |
| 2. Congenital Heart Defect | ☐ Yes | ☐ No |
| 3. Down Syndrome | ☐ Yes | ☐ No |
| 4. Tay-Sachs | ☐ Yes | ☐ No |
| 5. Sickle Cell Disease or Sickle Cell Trait | ☐ Yes | ☐ No |
| 6. Hemophilia or Bleeding Problems | ☐ Yes | ☐ No |
| 7. Muscular Dystrophy | ☐ Yes | ☐ No |
| 8. Cystic Fibrosis or Canavan Disease | ☐ Yes | ☐ No |
| 9. Mental Retardation / Autism / Learning Disability | ☐ Yes | ☐ No |
| If Yes: Tested for Fragile X ☐ Yes ☐ No | | |
| 10. Huntington Chorea | ☐ Yes | ☐ No |
| 11. Other Inherited Genetic or Chromosomal Disorder | ☐ Yes | ☐ No |
| 12. Maternal Metabolic Disorder (ie Insulin-Dependent Diabetes, PKU) | ☐ Yes | ☐ No |
| 13. Patient or Baby's Father Had a Child With Birth Defects Not Listed Above | ☐ Yes | ☐ No |
| 14. Recurrent Pregnancy Loss, or Stillbirth | ☐ Yes | ☐ No |
| 15. Blindness/Loss of vision or Deafness/Hearing loss | ☐ Yes | ☐ No |
| 16. Bone or Skeletal Disorder (ie Dwarfism) | ☐ Yes | ☐ No |

**Comments:**

_____

_____

**Do you currently take or have you taken any medications, vitamins or supplements during this pregnancy:**

| Medication Name and Dosage | How often do you take this medication? |
|---|---|
| ***Example: Iron 325 mg*** | ***Twice per day*** |
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