OBSTETRIX MEDICAL GROUP

Obstetric History Questionnaire

Patient Name: ______________________________ **Date:** ____________________

Social Security Number: ______________________

Are you currently pregnant: ☐ Yes ☐ No

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

What is your due date: ____________________

Are there any problems with your current pregnancy?

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Prior Pregnancies:

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

__________ **Number of miscarriages**

__________ **Number of tubal pregnancies (ectopic pregnancies)**

__________ **Number of abortions**

__________ **Number of living children**

Fill information in table below for each pregnancy start with your first one:

Year	Weeks	Labor Length	Birth Wt LB. / OZ.	Sex	Type Of Delivery	Anesthesia	Place

OBSTETRIX MEDICAL GROUP

Patient Name: ______________________________

Total Pregnancies	Full Term	Premature	Abortion Induced	Abortion Spontaneous	Ectopics	Multiple Births	Living Children

Comments: ____

Reviewed By ________________________________
Provider Name

OBSTETRIX MEDICAL GROUP

Patient Name: ______________________________
Social Security Number: ____________________
Date: ____________________

Genetic / Family History Questionnaire

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

☐ White	☐ French Canadian	☐ Samoan	☐ Vietnamese
☐ African (Black)	☐ Native American	☐ Chinese	☐ Laos
☐ Hispanic	☐ Greek	☐ Cambodian	☐ Taiwanese
☐ Ashkenazi Jewish	☐ Italian	☐ Filipino	☐ Korean
☐ Cajun	☐ Middle Eastern	☐ Japanese	☐ Other Southeast Asian
☐ Guamanian	☐ Hawaiian	☐ Asian-East Indian	☐ Unknown Race
☐ Other ____________		☐ 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):

☐ White	☐ French Canadian	☐ Samoan	☐ Vietnamese
☐ African (Black)	☐ Native American	☐ Chinese	☐ Laos
☐ Hispanic	☐ Greek	☐ Cambodian	☐ Taiwanese
☐ Ashkenazi Jewish	☐ Italian	☐ Filipino	☐ Korean
☐ Cajun	☐ Middle Eastern	☐ Japanese	☐ Other Southeast Asian
☐ Guamanian	☐ Hawaiian	☐ Asian-East Indian	☐ Unknown Race
☐ Other ____________		☐ Other ____________	

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

Comments: ______________________________

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Patient Name: ______________________________

Genetic / Family History Questionnaire

Do you, the father of this baby, or any close relatives have:

1. Thalassemia (Greek, Mediterranean, or Asian Background) MCV < 80 ☐ Yes ☐ No
2. Neural Tube Defect (Meningomyelocele Spina Bifida, or Anencephaly) ☐ Yes ☐ No
3. Congenital Heart Defect ☐ Yes ☐ No
4. Down Syndrome ☐ Yes ☐ No
5. Tay-Sachs (EG, Jewish, Cajun, French Canadian) ☐ Yes ☐ No
6. Sickle Cell Disease or Trait (African) ☐ Yes ☐ No
7. Hemophilia or Bleeding Problems ☐ Yes ☐ No
8. Muscular Dystrophy ☐ Yes ☐ No
9. Cystic Fibrosis or Canavan Disease ☐ Yes ☐ No
10. Mental Retardation / Autism / Learning Disorder ☐ Yes ☐ No
    If Yes: Tested for Fragile X ☐ Yes ☐ No
11. Huntington Chorea ☐ Yes ☐ No
12. Other Inherited Genetic or Chromosomal Disorder ☐ Yes ☐ No
13. Maternal Metabolic Disorder (EG, Insulin-Dependent Diabetes, PKU) ☐ Yes ☐ No
14. Patient or Baby's Father Had a Child With Birth Defects Not Listed Above ☐ Yes ☐ No
15. Recurrent Pregnancy Loss, or Stillbirth ☐ Yes ☐ No
16. Blindness or Deafness ☐ Yes ☐ No
17. Bone or Skeletal Disorder (Dwarfism) ☐ Yes ☐ No
18. Breast, Ovarian or Colon Cancer ☐ Yes ☐ No
19. Kidney Disorder ☐ Yes ☐ No
20. Do either you or any of your parents, siblings, or children have diabetes ☐ Yes ☐ No
21. Blood Clots / Stroke ☐ Yes ☐ No
22. Have you taken any medications other than PN vitamins since becoming pregnant ☐ Yes ☐ No
    If Yes what type: ______________________________
23. Have you used any street drugs since becoming pregnant ☐ Yes ☐ No
    If Yes what type: ______________________________
24. Have you consumed any alcoholic beverages since becoming pregnant ☐ Yes ☐ No
    If Yes what type: ______________________________
25. Any Other ☐ Yes ☐ No
26. Anything that seems to run in the family ☐ Yes ☐ No

Comments: ______________________________

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Reviewed By ______________________________

OBSTETRIX MEDICAL GROUP

Patient Name: ______________________________________
Social Security Number: ______________________
Date: ____________________

Review Of Systems Questionnaire

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

Medications Taken	Dose Date Taken

Do you have any known allergies:

Do you currently smoke?

☐ Yes	☐ No	

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

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☐ Yes	☐ No	☐ Unsure	Heart Murmur
☐ Yes	☐ No	☐ Unsure	Mitral Valve Prolapse
☐ Yes	☐ No	☐ Unsure	Other Heart Valve Problems
☐ Yes	☐ No	☐ Unsure	Heart Attack
☐ Yes	☐ No	☐ Unsure	Heart Disease
☐ Yes	☐ No	☐ Unsure	Unexplained Chest Pains
☐ Yes	☐ No	☐ Unsure	Unexplained Fainting
☐ Yes	☐ No	☐ Unsure	Irregular Heart Beat
☐ 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, Chron’s Disease, etc.)
☐ Yes	☐ No	☐ Unsure	Dietary Restrictions
☐ 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

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☐ 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	Psychiatric / Mental / 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
☐ Yes	☐ No	☐ Unsure	Any Past Surgeries (if yes please list below)
☐ Yes	☐ No	☐ Unsure	Any Known Allergies

Past Surgeries:

Name of operation	Type of Anesthesia	Hospital	Surgeon

Comments: