[redacted] MEDNAX® HEALTH SOLUTIONS PARTNER [redacted]

Obstetric History Questionnaire

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

Are you currently pregnant: ☐ Yes ☐ No (If No, please skip to Pregnancy Information table below**)

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

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

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

Is this pregnancy a result of fertility treatments? ☐ No ☐ Yes **What type?**_____ **If donor egg, age of donor?**_____

Are there any problems with your current pregnancy? _____

Have you had any blood work to determine the baby's gender or genetic testing? ☐ No ☐ Yes :_____

****Fill information in table below for <u>each</u> pregnancy. Please start with your first one:**

Year	Weeks	Labor Length	Birth Wt LB. / OZ.	Sex	Type Of Delivery	Type of Anesthesia	Hospital/ Location	Complications
Example: 2/2/2008	*38 wks*	*14 hours*	*6lbs8oz*	*M*	*Vacuum*	*Epidural*	*Gwinett Medical Center, GA*	*Diabetes, low amniotic fluid*

Total Pregnancies	Full Term	Premature (<37 wks)	Miscarriages	Abortions	Ectopics	Multiple Births	Living Children

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:_____

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Review of Systems Questionnaire

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

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

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

Do you have any known allergies to any drugs? If yes, please list reaction:

Example: Penicillin- hives and rash

REVIEW OF SYSTEMS: PLEASE CHECK ANY CURRENT SYMPTOMS:

Constitutional	☐ Night sweats ☐ Fever ☐ Change in sleep ☐ 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 ☐ Inability to fall/stay asleep ☐ Bedtime wakening ☐ Apnea

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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Genetic / Family History Questionnaire

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

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)?**_____

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

What is your occupation? _____

From the list below, how would you describe your ancestry? _____

From the list below, how would you describe the father of the baby's ancestry? _____

☐ White	☐ French Canadian	☐ Samoan	☐ Vietnamese	☐ Cajun
☐ African American	☐ Native American	☐ Chinese	☐ Laos	☐ Hawaiian
☐ African	☐ Greek	☐ Cambodian	☐ Taiwanese	☐ Asian-East Indian
☐ Hispanic	☐ Italian	☐ Filipino	☐ Korean	☐ Other:_____
☐ Ashkenazi Jewish	☐ Middle Eastern	☐ Japanese	☐ Other SE Asian	_____

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

1. Greek, Mediterranean, or Asian Background	☐ Yes	☐ No
2. Neural Tube Defect (ie Meningomyelocele, 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 Sickle Cell Trait	☐ 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 Disability	☐ 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 (ie 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/Loss of vision or Deafness/Hearing loss	☐ Yes	☐ No
17. Bone or Skeletal Disorder (ie Dwarfism)	☐ Yes	☐ No

Comments: _____