[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:_____

REVISED: 10/17/2016

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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 swea ☐ Feve ☐ Change in sleep ☐ Unexplained weight los ☐ Recent trauma
Eyes	☐ Visual changes ☐ Double visic ☐ Blind spo ☐ Floate ☐ Rednes ☐ Glasses/contacts
ENT	☐ Nose bleed ☐ Ringing in ears ☐ ore throa ☐ Difficulty swallowin ☐ Ear pai ☐ Tooth pai ☐ Gum bleeding
Cardiovascular	☐ Chest pair ☐ hortness of breath ☐ welling ☐ alpitatior ☐ Fainting ☐ oss of consciousness
Respiratory	☐ Cough ☐ putum ☐ Wheezin ☐ oughing up bloo ☐ hortness of breat ☐ Exercise intolerance
GI	☐ bdominal pai ☐ Change in appetite ☐ ifficulty swallowing ☐ eartbu ☐ Vomiting ☐ lood in stool ☐ iarrhea ☐ onstipation
GU	☐ Difficulty urinating ☐ Pain with urinatior ☐ Blood in urine ☐ Incontinence ☐ Vaginal bleeding ☐ Vaginal discharge ☐ Pelvic pai ☐ Breast pair ☐ Breast lumps
Musculoskeletal	☐ oint pain ☐ oint swelling ☐ Decreased range of motion ☐ Back pain ☐ oss of movement
Skin	☐ tching ☐ 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? type 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: _____