

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 each 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
<i>Example: 2/2/2008</i>	<i>38 wks</i>	<i>14 hours</i>	<i>6lbs8oz</i>	<i>M</i>	<i>Vacuum</i>	<i>Epidural</i>	<i>Gwinett Medical Center, GA</i>	<i>Diabetes, low amniotic fluid</i>

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

Please list any complications during your previous pregnancies:

- | | | | |
|--|-------------------------------------|--|--|
| <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Short cervix/cerclage | <input type="checkbox"/> Stillbirth |
| <input type="checkbox"/> Depression | <input type="checkbox"/> Blood clot | <input type="checkbox"/> IUGR/small baby | <input type="checkbox"/> Macrosomia/large baby |

Long term hospitalization during the pregnancy: Why? _____

Other specific complications: _____

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?
<i>Example: Iron 325 mg</i>	<i>Twice per day</i>

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

<i>Example: Penicillin- hives and rash</i>

REVIEW OF SYSTEMS: PLEASE CHECK ANY CURRENT SYMPTOMS:

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

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? _____

- | | | | | |
|---|--|------------------------------------|---|--|
| <input type="checkbox"/> White | <input type="checkbox"/> French Canadian | <input type="checkbox"/> Samoan | <input type="checkbox"/> Vietnamese | <input type="checkbox"/> Cajun |
| <input type="checkbox"/> African American | <input type="checkbox"/> Native American | <input type="checkbox"/> Chinese | <input type="checkbox"/> Laos | <input type="checkbox"/> Hawaiian |
| <input type="checkbox"/> African | <input type="checkbox"/> Greek | <input type="checkbox"/> Cambodian | <input type="checkbox"/> Taiwanese | <input type="checkbox"/> Asian-East Indian |
| <input type="checkbox"/> Hispanic | <input type="checkbox"/> Italian | <input type="checkbox"/> Filipino | <input type="checkbox"/> Korean | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> Ashkenazi Jewish | <input type="checkbox"/> Middle Eastern | <input type="checkbox"/> Japanese | <input type="checkbox"/> Other SE Asian | _____ |

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

- | | | |
|---|------------------------------|-----------------------------|
| 1. Greek, Mediterranean, or Asian Background | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 2. Neural Tube Defect (ie Meningocele, Spina Bifida, or Anencephaly) | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 3. Congenital Heart Defect | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 4. Down Syndrome | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 5. Tay-Sachs | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 6. Sickle Cell Disease or Sickle Cell Trait | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 7. Hemophilia or Bleeding Problems | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 8. Muscular Dystrophy | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 9. Cystic Fibrosis or Canavan Disease | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 10. Mental Retardation / Autism / Learning Disability | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| If Yes: Tested for Fragile X <input type="checkbox"/> Yes <input type="checkbox"/> No | | |
| 11. Huntington Chorea | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 12. Other Inherited Genetic or Chromosomal Disorder | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 13. Maternal Metabolic Disorder (ie Insulin-Dependent Diabetes, PKU) | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 14. Patient or Baby's Father Had a Child With Birth Defects Not Listed Above | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 15. Recurrent Pregnancy Loss, or Stillbirth | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 16. Blindness/Loss of vision or Deafness/Hearing loss | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 17. Bone or Skeletal Disorder (ie Dwarfism) | <input type="checkbox"/> Yes | <input type="checkbox"/> No |

Comments: _____

