Melbourne
Maternal-Fetal Medicine
an affiliate of MEDNAX

OBSTETRIC HISTORY QUESTIONNAIRE

Patient Name: _____ Today's Date: _____

DOB: _____ Social Security #: _____/_____/_____

Current Height?: _____ Current Weight?: _____

Are you currently pregnant? ☐ Yes ☐ No

If yes, what is your due date?: _____ Pre-Pregnancy Weight?: _____

What was the first day of your last menstrual period?: _____

Have you had any problems in the current pregnancy? ☐ Yes ☐ No

If yes, please specify:

_____

_____

Prior pregnancies

_____ Number of pregnancies (not including this one)

_____ Number of full term deliveries

_____ Number of preterm deliveries

_____ Number of pregnancies carried past 4 ½ months [20 weeks]

_____ Number of miscarriages [spontaneous]

_____ Number of voluntary abortions

_____ Number of ectopic [tubal] pregnancies

_____ Number of multiple births

_____ Number of living children

Please fill in the table below for all pregnancies, starting with the first, and include all pregnancies, living or deceased.

Year	Weeks Full term=40w ks	Length of Labor	Weight lbs oz	Sex (circle one)	Anesthesia	Type of delivery (i.e. vaginal or C/S)	Hospital
		hrs	lbs oz	M F			
		hrs	lbs oz	M F			
		hrs	lbs oz	M F			
		hrs	lbs oz	M F			
		hrs	lbs oz	M F			
		hrs	lbs oz	M F			
		hrs	lbs oz	M F			
		hrs	lbs oz	M F			

Melbourne
Maternal-Fetal Medicine
an affiliate of MEDNAX

What medications do you take currently (including prenatal vitamins)?			
Medication	**Dose**	**How many times a day?**	**For how long?**

Were you taking any other medications when you became pregnant? ☐ Yes ☐ No

If yes, please list:

Medication	**Strength**	**Dose**

Do you drink alcohol? ☐ Yes ☐ No

If yes, how often during the pregnancy _____

How often before pregnancy _____

Do you use illicit drugs ("street drugs")? _____ I have never used drugs.

___ I used drugs in the past. ___ I used drugs before pregnancy. ___I am still using drugs.

Drug	**How often**

Patient Name: _____ **DOB:** _____

Melbourne
Maternal-Fetal Medicine
an affiliate of MEDNAX

MEDICAL HISTORY

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 Persons(s) With Tuberculosis
☐ Yes	☐ No	☐ Unsure	Tuberculosis Vaccine (BCG)
☐ 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
☐ 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, Crohn's Disease, Etc.)
☐ Yes	☐ No	☐ Unsure	Dietary Restriction
☐ 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

Melbourne
Maternal-Fetal Medicine
an affiliate of MEDNAX

Patient Name: _____ **DOB:** _____

(cont.) **Do YOU have, or have you had, any of the following conditions:**			
☐ 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 Smear(s)
☐ Yes	☐ No	☐ Unsure	Diabetes (High Blood Sugar)
☐ Yes	☐ No	☐ Unsure	Thyroid Problems
☐ Yes	☐ No	☐ Unsure	Other Hormone Problem
☐ Yes	☐ No	☐ Unsure	Epilepsy, Seizure Disorder
☐ 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 If Yes, Date / Reason
☐ Yes	☐ No	☐ Unsure	Bleeding Tendency
☐ Yes	☐ No	☐ Unsure	Blood Clots, Thrombophlebitis
☐ Yes	☐ No	☐ Unsure	Rh Sensitized
			Do you currently smoke? _____I have never smoked. ___I smoke every day. Number of packs per day? _____ For how many years? _____ ___ I smoke but not every day. How often do you smoke? _____ ___ I smoked in the past but not currently. When did you quit? _____

Reviewed by _____
Provider signature

Melbourne
Maternal-Fetal Medicine
an affiliate of MEDNAX

Patient Name: _____ **DOB:** _____

Do you have any additional medical problems?

Date	Medical Problem	Medications or Treatment	Resolved?

Any Previous Surgeries? (include minor or outpatient surgeries such as wisdom tooth removal, D&C, etc.)

Year	Procedure	Hospital

Any allergies to medications? ☐ Yes ☐ No

Medication	Reaction

Any other Problems	

Melbourne
Maternal-Fetal Medicine
an affiliate of MEDNAX

Patient Name: _____ **DOB:** _____

GENETIC/FAMILY HISTORY

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

☐ Caucasian (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 (2)	

Are you and the father of this baby blood relative (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):

☐ Caucasian (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 2	

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

Comments: _____

_____

_____

Melbourne
Maternal-Fetal Medicine
an affiliate of MEDNAX

Patient Name: _____ **DOB:** _____

Does the father of the baby, or any close relative of yours or the father, have any of the following (if yes, please note who):

Disease/Condition	Yes	No	Relation
1. Thalassemia MCV<80			
2. Neural Tube Defect (Spina Bifida, or Anencephaly)			
3. Congenital Heart Defect			
4. Down Syndrome			
5. Tay-Sachs			
6. Sickle Cell Disease or Trait			
7. Hemophilia or bleeding Problems -Type:			
8. Muscular Dystrophy			
9. Cystic Fibrosis			
10. Canavan Disease			
11. Mental Retardation/Autism/Learning disorder			
If Yes, Tested for Fragile X			
12. Huntington Chorea			
13. Other inherited genetic or chromosomal disorder			
14. Maternal Metabolic Disorder (i.e. Insulin-Dependent Diabetes, PKU)			
15. Patient or baby's father had a child with birth defects not listed above			
16. Recurrent pregnancy loss, or stillbirth			
17. Blindness or deafness			
18. Bone or skeletal disorder			
19. Breast, ovarian or colon cancer			
20. Kidney disorder			
21. Do any of your parents, siblings, or children have diabetes			
22. Blood clots/stroke			
23. Anything else that seems to run in the family			

Reviewed by: _____ _____
Physician Signature Date

_____ _____
Patient Signature Printed Name of Patient