

OB/GYN

Obstetrics Questionnaire



Name: _____ Date of Birth : _____

Father of Baby/Support Person's Name: _____

How old will you be by your due date? ____ years old.

Have you have had chicken pox or shingles or have been vaccinated for chicken pox? YES NO

Is this pregnancy the result of infertility treatments? YES NO If so, what kind? _____

Are you interested in screening for birth defects and chromosomal abnormalities (ultrasound and blood tests offered to all pregnant women)? YES NO MAYBE

Do you want a blood test panel to determine if you carry the gene(s) for certain diseases including:

Cystic Fibrosis, Sickle Cell Disease, Tay Sachs Disease, Small Muscular Atrophy, Alpha and Beta Thalasemia YES NO

For both you and the father of the baby, is there a family history of:

Mother's Family **Father's Family**

- Children who died before birth or shortly after
- Cystic Fibrosis
- Diabetes
- Downs Syndrome
- Hemophilia
- Huntington's Chorea

Mother's Family **Father's Family**

- Mental retardation
- Muscular Dystrophy
- Neural tube defects
- Tay Sachs Disease
- Thalassemia
- Other Chromosomal disorders or birth defects

First day of your last menstrual period. _____

Was it normal? YES NO

How far apart are your menstrual cycles? _____ Days

Are they regular or irregular? _____

Date of positive pregnancy test? _____

Was this pregnancy conceived on birth control pills? YES NO

I am of the following ethnicity: (please circle)

Asian African-American Caucasian French-Canadian Jewish Hispanic Mediterranean Other

The father of the baby is of the following ethnicity: (please circle)

Asian African-American Caucasian French-Canadian Jewish Hispanic Mediterranean Other

Do you own a cat? YES NO Who changes the litter box? _____

Would you accept a blood transfusion to save your life? Yes No HIV testing will be done with your routine labs

Patient Signature: _____ Date: _____