

## 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:**

<b>Constitutional</b>	<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
<b>Eyes</b>	<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
<b>ENT</b>	<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
<b>Cardiovascular</b>	<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
<b>Respiratory</b>	<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
<b>GI</b>	<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
<b>GU</b>	<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
<b>Musculoskeletal</b>	<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
<b>Skin</b>	<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
<b>Neurological</b>	<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
<b>Psychiatric</b>	<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
<b>Endocrine</b>	<input type="checkbox"/> Mood swings <input type="checkbox"/> Excessive sweating <input type="checkbox"/> Irregular periods <input type="checkbox"/> Hot or Cold intolerance
<b>Hematologic</b>	<input type="checkbox"/> Bruising <input type="checkbox"/> Excessive bleeding <input type="checkbox"/> History of blood transfusion
<b>Sleep</b>	<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:** \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_