OBSTETRIX MEDICAL GROUP

Obstetric History Questionnaire

Patient Name: _____

Social Security Number: _____

Date: _____

Are you currently pregnant? ☐ Yes ☐ No

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

What is your due date? _____

Are there any problems with your current pregnancy? If yes, please describe them below.

_____

_____

_____

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Prior Pregnancies:

_____ **Number of pregnancies continued past 4 ½ months (20 weeks)**

_____ **Number of miscarriages**

_____ **Number of tubal pregnancies (ectopic pregnancies)**

_____ **Number of abortions**

_____ **Number of living children**

Fill information in table below for each pregnancy starting with your first one:

Year	Weeks	Labor Length	Birth Weight LB. / OZ.	Sex	Type Of Delivery	Anesthesia	Place

Total Pregnancies	Full Term	Premature	Abortion Induced	Abortion Spontaneous	Ectopics	Multiple Births	Living Children

Comments: _____

Reviewed By: _____
Provider Name

OBSTETRIX MEDICAL GROUP

Genetic / Family History Questionnaire

Patient Name: _____
Social Security Number: _____
Date: _____

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

☐ 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 _____	

Are you and the father of this baby blood relatives (for 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)?

☐ 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 _____	

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

Comments: _____

Genetic / Family History Questionnaire – continued

Do you, the father of this baby, or any close relatives have any of the following conditions?

1. Thalassemia (Greek, Mediterranean, or Asian Background) MCV < 80 ☐ Yes ☐ No
2. Neural Tube Defect (Meningomyelocele Spina Bifida, or Anencephaly) ☐ Yes ☐ No
3. Congenital Heart Defect ☐ Yes ☐ No
4. Down syndrome ☐ Yes ☐ No
5. Tay-Sachs (e.g., Jewish, Cajun, French Canadian) ☐ Yes ☐ No
6. Sickle Cell Disease or Trait (African) ☐ 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 Disorder ☐ 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 (e.g., 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 or Deafness ☐ Yes ☐ No
17. Bone or Skeletal Disorder (Dwarfism) ☐ Yes ☐ No
18. Breast, Ovarian or Colon Cancer ☐ Yes ☐ No
19. Kidney Disorder ☐ Yes ☐ No
20. Do either you or any of your parents, siblings, or children have diabetes? ☐ Yes ☐ No
21. Blood Clots / Stroke ☐ Yes ☐ No
22. Have you taken any medications other than prenatal vitamins since becoming pregnant? ☐ Yes ☐ No
    If Yes, what type? _____
23. Have you used any street drugs since becoming pregnant? ☐ Yes ☐ No
    If Yes, what type? _____
24. Have you consumed any alcoholic beverages since becoming pregnant? ☐ Yes ☐ No
    If Yes, what type? _____
25. Any Other Conditions that Run in Your Family ☐ Yes ☐ No
    If Yes, what type? _____

Comments: _____

Reviewed By: _____
Provider Name

OBSTETRIX MEDICAL GROUP

Review of Systems Questionnaire

Patient Name: _____
Social Security Number: _____
Date: _____

Do you currently take or have you taken any medication in the last year? If so, please list them here or write N/A (not applicable).

Medications Taken	Date Taken

Do you have any known allergies? If so, please list them here or write N/A (not applicable).

Do you currently smoke?

Yes	No

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 Person(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 Restrictions
Yes	No	Unsure	Unexplained Recurring Diarrhea
Yes	No	Unsure	Constipation
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
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 Smears
Yes	No	Unsure	Diabetes (High Blood Sugar)

Yes	No	Unsure	Thyroid Problems
Yes	No	Unsure	Other Hormone Problems
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 Attacks/Panic Disorder
Yes	No	Unsure	Psychiatric/Mental/Emotional Problems
Yes	No	Unsure	Skin Problems
Yes	No	Unsure	Unexplained Hair Loss
Yes	No	Unsure	Arthritis/Joint Pain
Yes	No	Unsure	Lupus
Yes	No	Unsure	Rheumatic Fever
Yes	No	Unsure	Blood Transfusions
Yes	No	Unsure	Bleeding Tendency
Yes	No	Unsure	Blood Clots/Thrombophlebitis
Yes	No	Unsure	Rh Sensitized
Yes	No	Unsure	Any Past Surgeries (if yes, please list below)
Yes	No	Unsure	Any Known Allergies

Past Surgeries: _____

_____

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Comments: _____

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Reviewed By: _____

Provider Name