GRWH OBSTETRIC QUESTIONNAIRE

Name: _____ Social Security # _____

Marital Status: M S D Sep Date of Birth: _____ Age: _____ Physician: _____

Address: _____ Hospital: _____

City: _____ Zip: _____ Referring Doctor: _____

Phone: Home_____Work_____ Cell_____

Your Occupation: _____

Name of Spouse/Father of baby: _____ His Age:_____

His Occupation: _____ His Phone:_____

Emergency Contact (name/relationship/phone number)_____

Have you had a positive pregnancy test? Yes / No If yes, where/when? _____
First Day of Last Period: _____ Are you certain of this date? Yes / No
How often do you get periods? _____ How many days does it last? _____
Were you using birth control? Yes / No If the pill, when did you stop? _____

Please check any of the following changes that you are experiencing:

___Spotting or bleeding	___Constipation	___Gums bleeding
___Breast tenderness	___Hemorrhoids	___Backache
___Abdominal cramps	___Tiredness	___Leg cramps
___Heartburn	___Sleeplessness	___Frequent urination
___Nausea	___Swelling	___Vaginal discharge
___Vomiting	___Dental Problems	___Shortness of breath

Please describe areas of concern above: _____
_____

Being pregnant is:

___Exciting	___Not planned	___Good	___Scary
___Not convenient	___Feeling good	___Feeling bad	___Too long

Is there anything in particular that is worrying you about yourself or your baby? _____
_____

Please list all previous pregnancies including miscarriages and abortions:

	Date	Hospital	Full Term Overdue	Length of labor	Type of del. Vag or C-sec Forceps?	Infant's Wt. & Sex	Your wt. gain
1							
2							
3							
4							
5							
6							

Complications during this pregnancy or during a previous pregnancy: _____
_____

Name _____ Date _____

Have you ever had or do you presently have any of the following? Please circle if yes or no and if yes, please give specifics, including date of onset and treatment:

Diabetes: Yes / No _____
High blood pressure or vascular problem: Yes / No _____
Heart Disease: Yes / No _____
Kidney Disease / urinary tract infections: Yes / No _____
Neurological problems or epilepsy: Yes / No _____
Psychiatric problems/Depression/Post Partum Depression: Yes / No _____
_____
Hepatitis: Yes / No _____
Stomach trouble/bowel disease: Yes / No _____
Thyroid Disease: Yes / No _____
Lung Disease (such as asthma): Yes / No _____
Abnormal Pap Smear or cervical biopsy/surgery: Yes / No _____
Circle if yes: Gonorrhea / Chlamydia / Syphilis / Herpes / Genital Warts (HPV) / HIV
Headaches: Yes / No _____
Arthritis/Lupus: Yes / No _____
Eating Disorder: Yes / No _____
Medication allergies: Yes / No _____
Gynecological problems or infertility: Yes / No _____
Surgeries or hospitalizations: Yes / No _____
_____
Blood Transfusions: Yes / No _____
Anemia: Yes / No _____
Do you have any other concerns related to your past health history? If so, please list: _____
_____
Do you smoke? Yes / No If yes, how much? _____
Do you use alcohol? Yes / No If yes, how often? _____
How many dairy servings (e.g. yogurt, cottage cheese, 8 ounces of milk, etc.) do you have per day?
_____
Are you on a restricted diet? (Vegetarian, Atkins, South Beach, etc.) _____

Please list the health history of your grandparents, parents, brothers, sisters (diabetes, heart disease, cancer, etc).

Grandparents _____
Mother / Father _____
Brothers / Sisters _____

Do you take any medications daily? Yes / No If yes, please list below, include any over-the-counter medications. Please include dosage and how often you take the medication:

1. _____
2. _____
3. _____
4. _____

What medications have you taken since your last period, including prescriptions, over-the-counter drugs, multivitamins, other supplements, and any herbal medicines? _____
_____

Name _____ Date _____

The following is a list of genetic problems. We need to know if you, the baby's father, or anyone in either of your families have had any of these problems and if so, who?

Down Syndrome: Yes / No _____
Mental retardation of other causes: Yes / No _____
If so, were they tested for Fragile X? _____
Spina bifida (open spine): Yes / No _____
Do you or the baby's father have a child with any birth defects? Yes / No _____
If Jewish, have you been tested for TaySach's? Yes / No _____
Sickle Cell disease or trait: Yes / No _____
Hemophilia: Yes / No _____
Muscular Dystrophy: Yes / No _____
Cystic Fibrosis: Yes / No _____
Huntington's Chorea: Yes / No _____
If Italian, Greek, Mediterranean or Asian, do you have anemia or thalassemia? Yes / No
_____
Do you have any other inherited, genetic or chromosomal disorder? Yes / No _____
_____
Are there twins in either immediate family? Yes / No If yes, please specify relationship to you or father of baby: _____

Does your job involve any heavy lifting? Yes / No _____
Does your job involve any exposure to hazardous chemicals? Yes / No _____
Do you exercise regularly? Yes / No If yes, what kind of exercise and how often? _____
_____
Do you wear a seat belt when you travel? Yes / No
Do you have a pet cat? If yes, do you change the litter box or does someone else do it? _____
Who comforts you when you have a problem? _____
The baby's father is:

___Understanding	___Gives me a lot of attention	___Excited
___Not around	___Will help with the baby	___Helpful
___Not caring	___Shares responsibility	___Willing to learn

Are you planning to breast or bottle feed: _____
Do you have any religious objections to any form of medical treatment (e.g. refusal of blood transfusion, male physician) that we should know about? If yes, please describe _____
_____
Do you fear for your safety or is there physical, verbal or emotional abuse where you live?
Yes / No _____
Any other information that we should be aware of? _____
_____
_____

PATIENT'S SIGNATURE _____ DATE _____