

**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:**

- |   |  |  |
|---|--|--|
| <input type="checkbox"/> Spotting or bleeding | <input type="checkbox"/> Constipation    | <input type="checkbox"/> Gums bleeding       |
| <input type="checkbox"/> Breast tenderness    | <input type="checkbox"/> Hemorrhoids     | <input type="checkbox"/> Backache            |
| <input type="checkbox"/> Abdominal cramps     | <input type="checkbox"/> Tiredness       | <input type="checkbox"/> Leg cramps          |
| <input type="checkbox"/> Heartburn            | <input type="checkbox"/> Sleeplessness   | <input type="checkbox"/> Frequent urination  |
| <input type="checkbox"/> Nausea               | <input type="checkbox"/> Swelling        | <input type="checkbox"/> Vaginal discharge   |
| <input type="checkbox"/> Vomiting             | <input type="checkbox"/> Dental Problems | <input type="checkbox"/> Shortness of breath |

Please describe areas of concern above: \_\_\_\_\_  
 \_\_\_\_\_

Being pregnant is:

- |   |                                       |                                      |                                   |
|---|---------------------------------------|--------------------------------------|-----------------------------------|
| <input type="checkbox"/> Exciting       | <input type="checkbox"/> Not planned  | <input type="checkbox"/> Good        | <input type="checkbox"/> Scary    |
| <input type="checkbox"/> Not convenient | <input type="checkbox"/> Feeling good | <input type="checkbox"/> Feeling bad | <input type="checkbox"/> 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 / 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: \_\_\_\_\_  
 \_\_\_\_\_

**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 oz 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 Signature \_\_\_\_\_

Date \_\_\_\_\_