New OB Questionnaire

Name: _____ DOB: _____ Date: _____

When was your last menstrual cycle? _____

Were you using birth control at the time of conception? Yes / No If yes, what type?_____

Have you recently experienced any of the following? If yes, please circle:

Nausea Vomiting Breast Tenderness Abdominal Pain Vaginal Bleeding Vaginal Discharge Headaches

How many pregnancies have you had? ____ Living Children ____ Miscarriages/Abortions ____ Multiple Births ____

Have you had any premature deliveries? Yes / No Have you had any ectopic pregnancies? Yes / No

Please list any previous pregnancy or labor complications you have had:

_____

Please list any previous fetal abnormalities: _____

Are your menstrual cycles regular? Yes / No How long do they typically last? _____

How frequent do they occur? _____ Are they: light / normal / heavy ?

Have you ever had an abnormal pap smear? Yes / No Have you had problems with infertility? Yes / No

Do you have any of the following significant medical problems? If yes, please circle:

Diabetes Hypertension Heart Disease Rheumatic Fever Blood Disorders Kidney

UTI Neurological Epilepsy Psychiatric Hepatitis Liver

GI Varicosities Phlebitis Thyroid Major Accidents Blood Transfusions

Have you had a rash or viral illness since your last period? Yes / No Have you been exposed to TB? Yes / No

Do you have a history of the following STD's? If yes, please circle:

Gonorrhea Chlamydia Herpes Syphilis Trichomonas

Do you eat wild game or raw meat? Yes / No

Do you have indoor cats? Yes / No

What is your marital status? _____ What is the baby's Father's name? _____

What is your occupation? _____ Do you have any environmental work hazards? Yes / No

Do you currently use tobacco? Yes / No Do you currently use alcohol? Yes / No

Do you currently use any drugs? Yes / No If yes, please list: _____

Do you currently use hot tubs or saunas? Yes / No Do you have a good support system at home? Yes / No

What are your current medications?_____

_____

Do you have any drug or latex allergies? If yes, please list:_____

_____

Are you related to the baby's father? Yes / No

Are there any known genetic disorders in either family? Yes / No If yes, please circle all that apply:

Down's Syndrome Cystic Fibrosis Thalassemia Hemophilia Neural Tube Defects Tay-Sachs

Huntington's Chorea Mental Retardation other inherited genetic/chromosomal disorders

Do you have a family history of any of the following:

Twins Diabetes Hypertension Heart Disease Pulmonary Disease

Renal Disease Endocrine Disorder Blood Disorder Malignancy