Dedicated to Women ObGyn

Obstetric Health History Questionnaire

Patient ID#: _____

Patient Date of Birth: _____ Date: _____

Patient's Name (Last, First, MI): _____ Maiden Name: _____

Emergency Contact Name: _____ Relationship: _____

Contact#: _____

Please check off if you or your blood relatives (NOT the baby's father's side of the family) have any of the following medical conditions:

SELF	FAMILY		SELF	FAMILY	
☐	☐	Diabetes _____	☐	☐	History of major accidents _____
☐	☐	High blood pressure _____	☐	☐	History of blood transfusion _____
☐	☐	Heart disease _____	☐	☐	Rh Sensitization _____
☐	☐	Autoimmune disorder (e.g. Lupus) _____	☐	☐	Asthma, TB or other lung problems _____
☐	☐	Kidney disease or urinary tract infections _____	☐	☐	Seasonal allergies _____
☐	☐	Neurologic disease or epilepsy _____	☐	☐	Breast disease _____
☐	☐	Psychiatric disorder _____	☐	☐	History of abnormal pap smears _____
☐	☐	Depression or postpartum depression _____	☐	☐	Uterine abnormalities _____
☐	☐	Hepatitis or liver disease _____	☐	☐	Infertility _____ Any infertility treatment? _____
☐	☐	Abnormal blood clots in the legs or lungs _____	☐	☐	Phenylketonuria _____
☐	☐	Varicose veins or phlebitis _____	☐	☐	Any kind of complication related to anesthesia
☐	☐	Thyroid problems _____			_____

Have you ever been hospitalized, except for childbirth? ☐ YES ☐ NO If Yes, When? _____ Why? _____

Have you had any type of gynecologic surgery? ☐ YES ☐ NO If Yes, When? _____ Why? _____

Have you had any other surgery? ☐ YES ☐ NO If Yes, When? _____ Why? _____

Please list any medications, including vitamins and herbal remedies, that you are taking or have recently stopped taking.

_____ _____

_____ _____

Do you have any allergies or know reactions to: Latex? ☐ YES Betadine/Iodine? ☐ YES Other? _____

Please list any Medications you are allergic to: _____

_____

Will you be 35 or older by the time the baby is born? ☐ YES ☐ NO

Are you planning to Breastfeed? ☐ YES ☐ NO

Do you have a Pediatrician selected? ☐ YES ☐ NO

If so, list Doctor/Practice name: _____

Is there a history of the following genetic disease in either you, the baby's father, relative of either side of the family, and if so, who has the condition?

☐ YES ☐ NO Thalassemia (Found in Italian, Greek, Mediterranean, Asian backgrounds) _____

☐ YES ☐ NO Neural tube defects (spine doesn't close properly) _____

☐ YES ☐ NO Born with heart defect _____

☐ YES ☐ NO Down Syndrome _____

☐ YES ☐ NO Tay Sachs (Ashkenazi Jewish, Cajun, French Canadian) _____

☐ YES ☐ NO Canavan Disease (Ashkenazi Jewish) _____

☐ YES ☐ NO Familial Dysautonomia (Ashkenazi Jewish) _____

☐ YES ☐ NO Sickle Cell Disease (African) _____

☐ YES ☐ NO Hemophilia or other blood disorders _____

☐ YES ☐ NO Muscular Dystrophy _____

☐ YES ☐ NO Cystic Fibrosis (More common in Caucasians) _____

☐ YES ☐ NO Huntington's Chorea _____

☐ YES ☐ NO Mental Retardation, Autism (If yes, was the person tested for Fragile X?) _____

☐ YES ☐ NO Other inherited or Chromosomal disorder _____

☐ YES ☐ NO Other birth defects _____

☐ YES ☐ NO Recurrent pregnancy loss or stillbirth _____

How old were you when you started your periods? _____ Are your periods regular? ☐ YES ☐ NO

How many days from the start of one to the start of the next? _____ How many days do they last? _____

When was your last menstrual period? _____ How sure are you of this date? _____

Please complete for each pregnancy:

Date of Delivery	# of weeks at delivery	Length of labor	Birth Weight	Sex (Male or Female)	Vaginal? Or C-Section	Place of Delivery	Comments/Complications (such as Preterm Labor, Diabetes, High Blood Pressure)

Please let us know if you've had any miscarriages, tubal pregnancies, or abortions, when they occurred, and any other details you think we might need to know.

_____

_____

Do you smoke/vape? ☐ YES ☐ NO How many a day? # Cigarettes_____ or # Packs _____

Have you ever smoked? ☐ YES ☐ NO How long? _____ Age started _____ Age stopped _____

Do you drink alcohol? ☐ YES ☐ NO Amount and frequency: _____

Do you use recreational or illegal drugs? ☐ YES ☐ NO Which? _____Amount _____

What is your ethnicity? ☐ Hispanic or Latino ☐ Not Hispanic or Latino What is your Religion?:_____

What is your Race: ☐ African-American ☐ Asian ☐ Caucasian ☐ Hispanic ☐ Native American Indian ☐ Pacific Islander

☐ Other _____

Name of Father of Baby: _____ His Age: _____

Father of Baby Ethnicity? ☐ Hispanic or Latino ☐ Not Hispanic or Latino

Father of Baby Race: ☐ African-American ☐ Asian ☐ Caucasian ☐ Hispanic ☐ Native American Indian ☐ Pacific Islander

☐ Other _____

Are you exposed to cats and/or cat litter boxes? ☐ YES ☐ NO

Do you live with someone with TB or have you been exposed to TB? ☐ YES ☐ NO

Do you or your partner have a history of genital herpes? ☐ YES ☐ NO

Have you had a rash or viral illness since your last menstrual period? ☐ YES ☐ NO

Is there a history of gonorrhea, chlamydia, HPV, HIV, syphilis? ☐ YES ☐ NO

Who is your employer? _____ What is your occupation? _____

Years of Education Completed?_____ Martial Status? ☐ Single ☐ Married ☐ Divorced

Do you work near: Children? ☐ YES ☐ NO Infectious diseases? ☐ YES ☐ NO Cats? ☐ YES ☐ NO

Rodents? ☐ YES ☐ NO Radiation? ☐ YES ☐ NO Other hazards? ☐ YES ☐ NO

Have you had Chicken Pox? ☐ YES ☐ NO

Would you accept a blood transfusion if medically recommended to save your life? ☐ YES ☐ NO

Has anyone close to you ever hurt you? ☐ YES ☐ NO Do you currently feel safe where you live? ☐ YES ☐ NO

Are you currently under care for mental health care by another provider? ☐ YES ☐ NO

Have you ever been diagnosed with a mental health condition? ☐ YES ☐ NO

If yes, please provide diagnosis: _____