Dedicated to Women | OB/GYN

# 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 Do you have a Pediatrician selected? ☐ YES ☐ NO
Are you planning to Breastfeed? ☐ 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 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) |
|---|---|---|---|---|---|---|---|
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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: _____