CONFIDENTIAL OB PATIENT QUESTIONNAIRE

Please take the time to answer the following questions as thoroughly as possible. The answers you provide help us to identify any potential inherited or exposure related risks to your unborn baby.

****Please bring this with you to your first appointment****

Today's Date: _____
Name of Patient: _____
Date of Birth: _____ Age: _____ Race _____
Occupation/Employer: _____ full time/part time
Last grade of school you attended _____
How old will you be when the baby is born? _____
Are you: Married ____ Single ____ Divorced ____ Separated _____ Widowed _____
Name of the Father of the Baby _____ Occupation/Employer_____
How old will the father of the baby be when the baby is born? _____
Phone number where the father of the baby can be reached: _____
Emergency contact person: (other than the father) Name: _____
Phone Number: _____ Relation to Patient: _____

What was the first day of your last menstrual period? _____
How old were you when you started your first period? _____
Do you normally have monthly periods? _____ I usually have a period every _____ days.
Were you on birth control pills at the time of conception? _____
Have you ever been pregnant before? Yes No
If yes, How many: Vaginal Deliveries? ____ C-Sections? _____ Miscarriages? _____
Terminations? _____ Ectopics?_____
If you have had previous deliveries, what hospital did you deliver at? _____
What date (s)? _____
Any complications? _____
What physician or pediatrician have you chosen to take care of the baby? _____

Past Medical History: Do you have or have you ever had: **Comments**

*Diabetes?	Yes	No	
*High Blood Pressure?	Yes	No	
*Heart Disease or a Heart Murmur?	Yes	No	
*Any Autoimmune Disorders? (i.e. Lupus)	Yes	No	
*Kidney Disease or Bladder Infections?	Yes	No	
*Neurological Disorders/Epilepsy/Migraines?	Yes	No	
*Psychiatric or Counseling Services?	Yes	No	
*Depression/Post Partum Depression/Anxiety?	Yes	No	
*Varicose Veins/Phlebitis/Blood Clots?	Yes	No	
*Thyroid Problems?	Yes	No	
*Cuts that required stitches/Broken Bones?	Yes	No	
*Asthma?	Yes	No	
*Seasonal Allergies?	Yes	No	
*Medication or Latex Allergies?	Yes	No	
*Breast Lumps, Bumps, or Biopsies?	Yes	No	
*Any other medical problems?	Yes	No	
*Hepatitis C	Yes	No	

<u>Past Surgical History</u> – Please list any surgeries you have had and the year:

_____
_____
_____

Any problems with anesthesia? _____
Have you ever had any GYN surgery? (D&C, Leep, Cryo) _____
Have you ever had an abnormal pap smear? Yes No
If yes, how was it treated? _____
Do you have any abnormal vaginal discharge? Yes No
Have you had any spotting? Yes No
Have you ever been told you have or have had a MRSA (methicillin resistant infection)? Yes No

During this pregnancy have you:	**Yes**	**No**	**Comments**
Had an x-ray examination?			
Been exposed to any contagious illnesses?			
Had a fever of 102 degrees for at least 2 days?			
Had any alcohol to drink?			
Smoked cigarettes?			
Used any recreational drugs?			

Patient's Family History

Please note *family history* of your immediate blood relatives. If they are living, note whether they have diabetes, blood pressure problems, heart disease or cancer. If they are deceased, what did they die from?

Examples:

Living—heart problems, diabetes

Deceased—breast cancer, stroke

Patient's MOTHER _____ Patient's FATHER _____

Patient's MOTHER"S MOTHER _____ Patient's MOTHER'S FATHER _____

Patient's FATHER'S MOTHER _____ Patient's FATHER'S FATHER _____

Number of Patient's SIBLINGS _____ ANY PROBLEMS _____

COMMENTS:_____
_____
_____
_____

<u>Pregnancy Symptoms:</u>
Since your last menstrual period have you had: (Circle all that apply)

Nausea, Vomiting, Fatigue, Breast Tenderness, Headache's?
Any other symptoms: _____

<u>Do you plan on:</u>
Breast Feeding or Bottle Feeding? (Circle)
Circumcision if you have a boy? Yes No
Using any type of birth control after the baby is born? Yes No Type: _____

Has there ever been anyone in *your* family or the *baby's father's* family affected with any of the following? Please circle all that apply.

***Thalassemia (This is a type of anemia most often found in Italian, Greek, Mediterranean, or Asian Background) Yes No**
***Any neural tube defect (meningomyelocele, spina bifida, or anencephaly) Yes No**
***Tay-sachs Yes No**
***Sickle cell disease or trait (African American) Yes No**
***Hemophilia or other blood disorders Yes No**
***Muscular dystrophy Yes No**
***Cystic Fibrosis Yes No**
***Huntington Chorea Yes No**
***Down's Syndrome Yes No**
***Mental Retardation/Autism Yes No**
***Congenital Heart Defect Yes No**
***Any other inherited or genetic chromosomal abnormalities? _____**

Past History

Do *you* or *your partner* have or had a history of: (Please circle all that apply)

Genital Herpes, HPV, Gonorrhea, Chlamydia, Syphilis, or any other sexually transmitted disease?_____

Are you or have you ever been physically, emotionally, or sexually abused? _____

Have you ever had the chicken pox? YES Have you had the Chicken Pox Vaccine? YES NO

How tall are you? _____ What is your current weight?_____

Have you had the seasonal flu vaccination? Yes (date)_____ No_____

Please note any questions or concerns you may have about this pregnancy?

_____
_____
_____

Please list any medications and dosages, if applicable, you have taken during this pregnancy or are currently on. This includes any over-the-counter medications

_____
_____
_____

If we need to contact you, where do you prefer we call?

Home # _____

Work # _____

Cell # _____

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