New OB Intake Patient Questionnaire

This questionnaire is a worksheet and may not be part of your permanent medical record.

****Esta forma también está disponible en español.***

Date: _____ Patient Name: _____ DOB: _____ Age: ____

Race of Patient: __ Caucasian __ African American __ American Indian __ Hispanic __ Asian __ Other

Race of father of baby: __ Caucasian __ African American __ American Indian __ Hispanic __ Asian __ Other

Patient Marital Status: _____ Patient Occupation: _____

Patient's Highest Level of Education Completed: _____

Name of Father of Baby:_____ Phone Number of Father of Baby: _____

Patient's Current Address: _____

Patient's Phone Numbers Including Cell Phone Numbers: _____

Insurance Carrier: _____

Please list who we can contact in an emergency and phone number: _____

Please list preferred Pharmacy: _____ Please list Pediatrician: _____

Menstrual History:

What was the first day of your last menstrual period? _____

Have you menses been regular over the past 6 months? _____ Yes _____ No

Was your last menses regular? _____ Yes _____ No

How long did your last menstrual flow last? _____ Days

Is this length of flow normal for you? _____ Yes _____ No
Have you used any more of hormonal contraception, (i.e. birth control pills, Depo Provera, Mirena IUD,

Implanon/Nexplanon, Nuva Ring, etc.) in the last 6 months? _____ Yes _____ No

If Yes, what method were you using and when did you stop? _____

_____

_____

New OB Intake Patient Questionnaire (continued)

Current Medications:

_____

_____

_____

_____

_____

_____

_____

Obstetrical History:

How many times have you been pregnant in your lifetime, including current pregnancy? (Please count all normal pregnancies, miscarriages, abortions, ectopic pregnancies, etc.) _____

Number of term pregnancies with delivery greater than 37 weeks: _____

Number of preterm pregnancies with delivery less than 37 weeks: _____

Have you had 2 or more spontaneous abortions (miscarriages): ___ Yes ___ No

Number of spontaneous abortions (miscarriages): _____

Number of ectopic pregnancies: _____

Number of multiple pregnancies (i.e. Twins or Triplets): _____

Total number of vaginal deliveries: _____

Total number of C-Sections: _____

Number of living children: _____

New OB Intake Patient Questionnaire (continued)

Please proved the following information regarding your previous pregnancies including deliveries, miscarriages, etc. Begin with the earliest date.

Date Mo/Yr	# of Weeks at Delivery or Miscarriage	Length of Labor	Birth Weight	Sex of Infant	Delivery Type (Vaginal or C-Section)	Anesthesia	Place of Delivery

Please list any complications that you have had during previous pregnancies:

_____

_____

_____

_____

_____

_____

New OB Intake Patient Questionnaire (continued)

Past Medical History: Have you ever been affected by any of the following conditions?

Diabetes	___ Yes	___ No
Hypertension (High Blood Pressure)	___ Yes	___ No
Heart Disease	___ Yes	___ No
Autoimmune Disorders (i.e. Lupus, Rheumatoid Arthritis, etc.)	___ Yes	___ No
Kidney Disease or Frequent Urinary Tract Infections	___ Yes	___ No
Musculoskeletal/Back Problems	___ Yes	___ No

If Yes, please explain: _____

_____

Neurologic Problems (i.e. Seizures/Epilepsy, Migraines, Multiple Sclerosis, etc.)	___ Yes	___ No
Psychiatric Problems (i.e. Treatment for Depression, Anxiety, Postpartum Depression, Posttraumatic Stress Disorder, Eating Disorder, Schizophrenia, etc.)	___ Yes	___ No
Hepatitis or Liver Disease	___ Yes	___ No
Varicosities or History of Blood Clots	___ Yes	___ No
Thyroid Problems	___ Yes	___ No
History of Major Trauma (i.e. Severe Car Accident, etc.)	___ Yes	___ No
Do you have lactose intolerance?	___ Yes	___ No
Are you a strict vegetarian?	___ Yes	___ No
Are you afraid of anyone close to you or have you been a victim of domestic violence in the past?	___ Yes	___ No
Have you ever had a previous blood transfusion?	___ Yes	___ No
Have you ever been under the care of pain management or substance abuse specialist?	___ Yes	___ No

If Yes, please explain: _____

_____

Have you ever had any lung problems, including asthma, pneumonia, or TB?	___ Yes	___ No

New OB Intake Patient Questionnaire (continued)

Have you ever had any complication of abnormal antibodies or Rh sensitization during previous pregnancy? ___ Yes ___ No

Exposure to extreme temperatures, prolonged standing or sitting, strenuous activity, or other extreme conditions? ___ Yes ___ No

If Yes, please explain: _____

_____

Please list all environmental allergies, i.e. food allergies, etc. (not including medications):

_____

_____

_____

Please list all allergies to medications: _____

_____

Family History:

Please review the medical conditions listed on the previous page from your medical history and list below if these conditions are presents in any close family member, (i.e. parents, grandparents, siblings):

_____

_____

_____

Social History/Habits:

Do you have a history of current or previous use of tobacco products in any way (i.e. smoking cigarettes, chewing tobacco, snuff, etc.)? ___ Yes ___ No

If yes, please list amount of use per day before becoming pregnant: _____

Please list the amount use currently since becoming pregnant: _____

Total number of years of tobacco use: _____

Do you have a history of current or previous alcohol use? ___ Yes ___ No

If yes, please describe previous and current use: _____

_____

New OB Intake Patient Questionnaire (continued)

Are you exposed to secondhand cigarette smoke or secondhand marijuana smoke? ___ Yes ___ No

If Yes, please explain: _____

_____

Do you have problems meeting basic needs (i.e. food, shelter, etc.)? ___ Yes ___ No

Do you have problems understanding spoken English? ___ Yes ___ No

Do you have problems reading or adequately understanding written English material? ___ Yes ___ No

Is there a lack of family support (i.e. emotional, financial, etc.)? ___ Yes ___ No

Do you feel threatened or afraid of someone close to you? ___ Yes ___ No

Unplanned pregnancy? ___ Yes ___ No

Do you have transportation problems preventing you from keeping appointments? ___ Yes ___ No

Gynecological History

Breast problems including masses, lumps, abnormal nipple discharge, or previous breast biopsies? ___ Yes ___ No

If Yes, please explain: _____

Have you ever had previous pelvic surgery? ___ Yes ___ No

If Yes, please explain: _____

Have you ever had any previous general (non-pelvis) surgery? ___ Yes ___ No

If Yes, please explain: _____

Have you ever been hospitalized other than for childbirth? ___ Yes ___ No

If Yes, please explain: _____

Have you ever had any compilations from anesthesia? ___ Yes ___ No

If Yes, please explain: _____

Have you ever had any abnormal Pap smears? ___ Yes ___ No

If Yes, please explain: _____

Have you ever been diagnosed with uterine anomalies, infertility, or polycystic ovaries? ___ Yes ___ No

New OB Intake Patient Questionnaire (continued)

Symptoms or Problems Since the Onset of Last Menstrual Period:

Visit to other physicians or emergency room? ___ Yes ___ No

If Yes, please explain: _____

_____

Have you had any of the following symptoms or problems since onset of your last menses?

Excessive nausea and vomiting and weight loss? ___ Yes ___ No

Vaginal bleeding? ___ Yes ___ No

Significant abdominal/pelvic pain? ___ Yes ___ No

Urinary Complaints? ___ Yes ___ No

Headaches not relieved by Tylenol? ___ Yes ___ No

Other problems? ___ Yes ___ No

If Yes, please list: _____

_____

Genetic Screening History:

Patient age greater than 35 years at time of expected delivery? ___ Yes ___ No

Please indicate whether there is any history of the following in yourself, baby's father, or anyone in either family:

History of known thalassemia or Italian, Greek, Mediterranean, or Asian background: ___ Yes ___ No

History of neural tube defects (i.e. meningocele, spina bifida, or anencephaly): ___ Yes ___ No

History of congenital heart defect: ___ Yes ___ No

History of Down Syndrome or other chromosomal abnormality: ___ Yes ___ No

History of Tay-Sachs disease or Jewish, Cajun, French, or Canadian ancestry: ___ Yes ___ No

History of sickle cell disease or trait or African American heritage: ___ Yes ___ No

History of hemophilia (free bleeder): ___ Yes ___ No

History of muscular dystrophy: ___ Yes ___ No

History of cystic fibrosis or carrier for cystic fibrosis: ___ Yes ___ No

History of Huntington's chorea: ___ Yes ___ No

History of mental retardation / autism: ___ Yes ___ No

History of other inherited genetic or chromosomal disorders: ___ Yes ___ No

History of metabolic disorders (i.e. PKU, etc.) ___ Yes ___ No

History of patient or baby's father previous child with birth defects not listed above: ___ Yes ___ No

Recurrent pregnancy loss or stillbirth: ___ Yes ___ No

History of medication use, street drugs use, alcohol use since last menstrual period began: ___ Yes ___ No

If Yes, please list: _____

_____

Have you had exposure to toxic chemicals (i.e. lead, mercury, or other toxic or poisonous chemicals?) ___ Yes ___ No

Have you had any exposure to x-rays since becoming pregnant? ___ Yes ___ No

Infection History

Are you at high risk for Hepatitis B or Hepatitis C due to history of drug abuse or contact with infected persons? ___ Yes ___ No

Do you live with someone with TB or have been exposed to persons with TB? ___ Yes ___ No

Do you or your sexual partner have any history of genital herpes? ___ Yes ___ No

Have you had a rash, viral illness, or fever since the onset of your last menstrual period? ___ Yes ___ No

Are you exposed to cats or rodent pets? ___ Yes ___ No

Are you employed as a daycare worker, elementary teacher, or similar exposure to numerous young children? ___ Yes ___ No

Are you a healthcare worker with patient exposure in a clinical setting? ___ Yes ___ No

Do you have any previous history of sexually transmitted disease (i.e. gonorrhea, chlamydia, HPV, syphilis, vaginal warts, etc.)? ___ Yes ___ No

Have you had more than 1 sexual partner in the past 2 years? ___ Yes ___ No

Are you concerned that your current partner may have had other sexual partners in the past 2 years? ___ Yes ___ No

Are you concerned that you could have been exposed to any sexually transmitted disease? ___ Yes ___ No

Please list any other items that you think are important regarding your health and current pregnancy:

_____

_____

_____

_____

_____

_____