

Obstetric New Patient Questionnaire ObGyn/North

Patient Name: _____ Date of Birth: _____

Father's Name (father of baby): _____ Age: _____

How did you hear about us: _____

Today's visit:

Current Complaints (i.e. Nausea/Vomiting/breast tenderness/bleeding): _____

Current Medications and Supplements:

Office use only: EDD: _____ GA: _____ PPWt: _____ Wt: _____ Ht: _____ BP: _____

Obstetrical History:

How many pregnancies have you had?	
How many pregnancies have you delivered at full term (>37 weeks)?	
How many pregnancies have you delivered prematurely (<37 weeks)?	
How many abortions have you had?	
How many miscarriages have you had?	
Have you ever had an ectopic (tubal) pregnancy?	
Have you ever had twins or triplets?	
How many children do you currently have living?	
On what date did you last menstrual period start?	
Are your menses monthly and regular?	
How many days from the start of one menses to the next?	
At what age did you first get your menses?	
On what date did you have your first positive pregnancy test?	

Patient Name: _____ Date of Birth: _____

Date of delivery:					
Weeks pregnant at time of delivery:					
Number of hours you labored:					
Birth weight of baby:					
Sex of baby:					
Mode of delivery: (vaginal/forceps/vacuum/c-section):					
Type of anesthesia used (none/IV meds/epidural):					
Place of delivery (home/birth center/hospital):					
Preterm Labor (yes or no):					
Name of baby:					
Additional comments:					

Please Circle all problems below that you have ever had and write any details about this problem. Please also indicate any family members who may have these problems. Example: Children, Parents, Siblings, Grandparents, Aunts, Uncles, 1st Cousins.

- Hypertension: _____
- Heart Disease: _____
- Autoimmune Disorder: (Lupus/Rheumatoid) _____
- Kidney disease/UTI: _____
- Neurologic/Epilepsy: _____
- Depression/Post partum Depression: _____
- Hepatitis/Liver Disease: _____
- Varicose Veins/ Phlebitis: _____
- Thyroid Disorders: _____
- Trauma/Violence: _____
- History of Blood Transfusion: _____
- Tobacco use (smoking): _____
- Alcohol: _____
- Illicit/Recreational Drug Use: _____
- D (Rh) Sensitivity: _____
- Pulmonary (TB/Asthma): _____
- Seasonal Allergies: _____
- Drug/Latex Allergies and Reactions: _____
- Breast Problems: _____
- Gyn Surgery: _____
- Operations/Hospitalizations: _____
- Anesthetic Complications: _____
- History of abnormal Pap smear: _____
- When was your last Pap smear: _____
- Uterine anomaly/ DES Exposure: _____

Patient Name: _____ Date of Birth: _____

Infertility: _____
Relevant Family History: _____
Diabetes: _____
Cancer: _____
Other: _____
Varicella immune? (Chicken pox): _____
Would you accept blood products: _____

Family Genetic History:

Patients age at time of delivery: _____
Any history of the following:
Thalassemia or are you of Italian, Greek, Mediterranean or Asian decent: _____
Neural Tube Defects: _____
Congenital heart defects: _____
Down syndrome: _____
Tay-Sachs: _____
Canavan disease: _____
Sickle cell disease or trait: _____
Hemophilia or other blood disorder: _____
Muscular dystrophy: _____
Cystic Fibrosis: _____
Mental Retardation/Autism: _____
If yes, was person test for fragile X: _____
Other inherited genetic or chromosomal disorder: _____
Recurrent pregnancy loss or stillbirth: _____
Medication/Illicit/Recreational drugs or alcohol since last menstrual period: _____
If yes, what agent and strength/dosage: _____
Any Other: _____

Infection History:

Live with someone with or been exposed to TB: _____
Patient or partner with genital or oral herpes (cold sores/fever blisters): _____
Rash or viral illness since last menstrual period: _____
History of STD: _____
Any other: _____
Do you have any cats: _____