Obstetric History Questionnaire

Patient Name: ___________________________ Date of Birth: __________ Date: ________

Are you currently pregnant:  □ Yes  □ No (If No, please skip to Drug Allergy Box Below**)

Are there any problems with your current pregnancy? __________________________

Height: _______ Pre-pregnancy weight: _______ Pharmacy Name_________________________ #(____)_____________________

What was the first day of your last menstrual period: _______ Definite date or Unknown date

What is your due date: ___________________ Preferred language:___________________

Do you smoke cigarettes?  □ No  □ Yes→ Number of packs per day: ______ Have you quit previously? ______

Do you drink alcoholic beverages?  □ No  □ Yes→ Number of drinks per week:__________

Do you use any recreational drugs?  □ No  □ Yes→Which one(s)?_________________

What is your occupation? __________________________

Is this pregnancy a result of fertility treatments?  □ No  □ Yes What type?_______ Donor egg? Y/ N Age of egg/donor? _____

Which fertility practice followed you? ________________ If IVF, fertilization date:_______________

Have you had any blood work to determine the baby’s gender?  □ No  □ Yes: Results:____________________

What other genetic testing have you had?  (Down syndrome screening? Cystic Fibrosis? AFP? Quad screen?) ________________________________________________________________

**Do you have any known allergies to any drugs? No □ If yes, please list drug and reaction:

Example: Penicillin- hives and rash

MEDICAL HISTORY:

PLEASE LIST ANY CHRONIC MEDICAL PROBLEMS YOU CURRENTLY HAVE OR HAD IN THE PAST:
Example: Any ER visits? Being worked up by provider for a health problem? Any illness that you took long term medication for?

1._______________________ 4._______________________ 7._______________________ 10._______________________
2._______________________ 5._______________________ 8._______________________ 11._______________________
3._______________________ 6._______________________ 9._______________________ 12._______________________

HAVE YOU EVER BEEN IN THE HOSPITAL OR HAD ANY SURGERY:

<table>
<thead>
<tr>
<th>SURGERY</th>
<th>Reason</th>
<th>Date</th>
<th>HOSPITALIZATION</th>
<th>Reason</th>
<th>DATE</th>
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REVIEW OF SYSTEMS: PLEASE CHECK ANY CURRENT SYMPTOMS:

Constitutional ☐ Night sweats  ☐ Fever  ☐ Unexplained weight loss ☐ Recent trauma
Eyes ☐ Visual changes  ☐ Double vision  ☐ Blind spots  ☐ Floaters  ☐ Redness  ☐ Glasses/contacts
ENT ☐ Nose bleeds  ☐ Ringing in ears  ☐ Sore throat  ☐ Difficulty swallowing ☐ Ear pain  ☐ Tooth pain  ☐ Gum bleeding
Cardiovascular ☐ Chest pain  ☐ Shortness of breath  ☐ Swelling  ☐ Palpitations  ☐ Fainting  ☐ Loss of consciousness
Respiratory ☐ Cough  ☐ Sputum  ☐ Wheezing  ☐ Coughing up blood  ☐ Shortness of breath  ☐ Exercise intolerance
GI ☐ Abdominal pain  ☐ Change in appetite  ☐ Difficulty swallowing  ☐ Heartburn  ☐ Vomiting  ☐ Blood in stool
☐ Diarrhea  ☐ Constipation
GU ☐ Difficulty urinating  ☐ Pain with urination  ☐ Blood in urine  ☐ Incontinence  ☐ Vaginal bleeding
☐ Vaginal discharge  ☐ Pelvic pain  ☐ Breast pain  ☐ Breast lumps
Musculoskeletal ☐ Joint pain  ☐ Joint swelling  ☐ Decreased range of motion  ☐ Back pain  ☐ Loss of movement
Skin ☐ Itching  ☐ Rash  ☐ Non-healing wound  ☐ Nodule  ☐ Excessive dryness  ☐ Change in skin color
Neurological ☐ Headache  ☐ Weakness  ☐ Seizures  ☐ Head trauma  ☐ Loss of consciousness  ☐ Dizziness  ☐ Confusion  ☐ Tremor
☐ Difficulty walking  ☐ Memory loss  ☐ Change in sight, smell, hearing or taste  ☐ Numbness
Psychiatric ☐ Anxiety  ☐ Depression  ☐ Panic  ☐ Excessive sadness  ☐ Tearfulness  ☐ Thoughts of suicide  ☐ Paranoia
Endocrine ☐ Mood swings  ☐ Excessive sweating  ☐ Irregular periods  ☐ Hot or Cold intolerance
Hematologic ☐ Bruising  ☐ Excessive bleeding  ☐ History of blood transfusion
Sleep ☐ Snoring  ☐ Apnea

Please list any complications during your previous pregnancies:
☐ High blood pressure  ☐ Diabetes  ☐ Short cervix/cerclage  ☐ Stillbirth
☐ Depression  ☐ Blood clot  ☐ IUGR/small baby  ☐ Macrosomia/large baby
☐ Long term hospitalization during the pregnancy: Why?______________________________
☐ Other specific complications: __________________________________________________

Fill information in table below for each pregnancy, include miscarriages and abortions
Please start with your first one:

<table>
<thead>
<tr>
<th>Date of Birth</th>
<th>Weeks</th>
<th>Labor Length</th>
<th>Birth Wt LB. / OZ.</th>
<th>Sex</th>
<th>Type Of Delivery</th>
<th>Type of Anesthesia</th>
<th>Hospital/Location</th>
<th>Complications</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ex: 2/2/2008</td>
<td>38</td>
<td>14 hrs</td>
<td>6lbs8oz</td>
<td>M</td>
<td>Vaginal or CSection</td>
<td>Epidural</td>
<td>Northside, GA, GA</td>
<td>Diabetes, low amniotic fluid</td>
</tr>
</tbody>
</table>

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<tr>
<th># Total Pregnancies</th>
<th># Full Term</th>
<th># Premature (&lt;37 wks)</th>
<th># Miscarriages</th>
<th># Abortions</th>
<th># Ectopics</th>
<th># Multiple Births</th>
<th># Living Children</th>
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</table>
Are you and the baby’s father related in any way (ie cousins)? □ No □ Yes→ Relationship:______________

In your family, are there any ancestors who are:
□ French Canadian □ Cajun □ Ashkenazi Jewish □ Africa □ Asia □ Mediterranean

If YES, explain: ________________________________

In the family of the father of this baby, are there any ancestors who are:
□ French Canadian □ Cajun □ Ashkenazi Jewish □ Africa □ Asia □ Mediterranean

If YES, explain: ________________________________

Do you, the father of this baby, or any close relatives have: If yes, explain in comment section and the relationship:
1. Neural Tube Defect (ie Meningomyelocele, Spina Bifida, or Anencephaly) □ Yes □ No
2. Congenital Heart Defect □ Yes □ No
3. Down Syndrome □ Yes □ No
4. Tay-Sachs □ Yes □ No
5. Sickle Cell Disease or Sickle Cell Trait □ Yes □ No
6. Hemophilia or Bleeding Problems □ Yes □ No
7. Muscular Dystrophy □ Yes □ No
8. Cystic Fibrosis or Canavan Disease □ Yes □ No
9. Mental Retardation / Autism / Learning Disability □ Yes □ No
   If Yes: Tested for Fragile X □ Yes □ No
10. Huntington Chorea □ Yes □ No
11. Other Inherited Genetic or Chromosomal Disorder □ Yes □ No
12. Maternal Metabolic Disorder (ie Insulin-Dependent Diabetes, PKU) □ Yes □ No
13. Patient or Baby’s Father Had a Child With Birth Defects Not Listed Above □ Yes □ No
14. Recurrent Pregnancy Loss, or Stillbirth □ Yes □ No
15. Blindness/Loss of vision or Deafness/Hearing loss □ Yes □ No
16. Bone or Skeletal Disorder (ie Dwarfism) □ Yes □ No

Comments:
___________________________________________________________________________________________________________
_________________________________________________________________________________________

Do you currently take or have you taken any medications, vitamins or supplements during this pregnancy:

<table>
<thead>
<tr>
<th>Medication Name and Dosage</th>
<th>How often do you take this medication?</th>
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<tbody>
<tr>
<td>Example: Iron 325 mg</td>
<td>Twice per day</td>
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