

Name: _____ Date: _____ APPT. DATE: _____

Age: _____ Birthday: _____ Race: _____

OBSTETRIC QUESTIONNAIRE

By providing the following information, you will enable us to give individualized care in areas of concern to you and your family, should you be or become pregnant.

1. Occupation: _____
2. Husband's occupation: _____
3. How many times have you been pregnant? (Including this pregnancy) _____
4. How many pregnancies did you carry until term? (At least 37 weeks) _____
5. How many pregnancies did you delivery prior to 37 weeks? _____
6. How many spontaneous miscarriages have you had? _____
7. How many voluntary abortions have you had? _____
8. How many stillborn children have you had? _____
9. How many ectopics have you had? (Pregnancies in tubes or outside the uterus) _____
10. How many pregnancies have you had with multiple births? (Twins, triplets, etc.) _____
11. When did your last normal period start? _____
12. Do you have normal monthly periods? YES NO They occur every _____ days
13. How old were you when you first started having periods? _____
14. Were you taking birth control pills when you became pregnant? _____
15. What was your pre-pregnant weight? (Just prior to your pregnancy) _____

MEDICAL HISTORY:

Have you had any of the following? ----- If YES - Please describe condition/treatment

1. Diabetes NO YES _____
2. High blood pressure NO YES _____
3. Heart Disease NO YES _____
4. Autoimmune disorders NO YES _____
5. Kidney disease NO YES _____
6. Neurological problems NO YES _____
7. Epilepsy NO YES _____
8. Psychiatric problems NO YES _____
9. Depression NO YES _____
10. Postpartum depression NO YES _____
11. Hepatitis NO YES _____
12. Liver disease NO YES _____
13. Phlebitis (blood clots in deep veins) NO YES _____
14. Thyroid disease NO YES _____
15. Trauma NO YES _____
16. Physical abuse NO YES _____
17. Sexual abuse NO YES _____
18. Blood transfusion NO YES _____
19. Tuberculosis NO YES _____
20. Asthma NO YES _____
21. Seasonal allergies NO YES _____
22. Latex allergy NO YES _____
23. Breast problems/surgery NO YES _____
24. Anesthetic complications NO YES _____
25. Abnormal pap smear NO YES _____
26. Uterine abnormalities NO YES _____
27. Infertility NO YES _____

If yes: Name of infertility specialist? _____ Cause of infertility? (If known) _____

28. Please give your history of conceiving this pregnancy. Conception without assistance Clomid Intrauterine Insemination (IUI) Date: _____ In-Vitro (IVF) Date of retrieval: _____ Date of transfer: _____

Were donor eggs used? YES NO If yes, what was the age of the donor at the time of fertilization? _____

29. Other _____

GENETIC SCREENING (Patient, baby's father, or anyone in either family)

1. How old will you be at the birth of this baby? (If you are currently pregnant) _____
2. How old will your husband be at the birth of this baby? (If you are currently pregnant) _____
3. Any family history of THALASSEMIA (Italian, Greek, Mediterranean, or Asian background)? NO YES
If yes, indicate the relationship of the affected person to you or the baby's father. _____
4. Any family history of NEURAL TUBE DEFECTS (Meningomyelocele, Spina Bifida, or Anencephaly)? NO YES
If yes, indicate the relationship of the affected person to you or the baby's father. _____
5. Any family history of CONGENITAL HEART DEFECTS? NO YES
If yes, indicate the relationship of the affected person to you or the baby's father. _____
6. Any family history of Down syndrome? NO YES
If yes, indicate the relationship of the affected person to you or the baby's father. _____
7. Any family history of TAY-SACHS (e.g. Jewish, Cajun, or French Canadian)? NO YES
If yes, indicate the relationship of the affected person to you or the baby's father. _____
8. Any family history of CANAVAN DISEASE? NO YES
If yes, indicate the relationship of the affected person to you or the baby's father. _____
9. Any family history of FAMILIAL DYSAUTONOMIA (Ashkenazi Jewish inheritance)? NO YES
If yes, indicate the relationship of the affected person to you or the baby's father. _____
10. Any history of SICKLE disease or trait (African)? NO YES
If yes, indicate the relationship of the affected person to you or the baby's father. _____
 - a. Have you ever been tested for SICKLE disease or trait? NO YES
If yes, what was the result of your test? _____
 - b. Has you husband ever been tested? NO YES
If yes, what was the result of his test? _____
11. Any history of HEMOPHILIA or other blood disorders? NO YES
If yes, indicate the relationship of the affected person to you or the baby's father. _____
12. Any history of MUSCULAR DYSTROPHY? NO YES
If yes, indicate the relationship of the affected person to you or the baby's father. _____
13. Any history of CYSTIC FIBROSIS? NO YES
If yes, indicate the relationship of the affected person to you or the baby's father. _____
Do you want to be tested for the CYSTIC FIBROSIS? NO YES
14. Any history of HUNTINGTON'S CHOREA? NO YES
If yes, indicate the relationship of the affected person to you or the baby's father. _____
15. Any history of MENTAL RETARDATION? NO YES
If yes, indicate the relationship of the affected person to you or the baby's father. _____
If yes, was the person tested for FRAGILE X? NO YES
If yes, indicate the relationship of the affected person to you or the baby's father. _____
16. Any INHERITED GENETIC OR CHROMOSOMAL DISORDER? NO YES
If yes, indicate the disorder and the relationship of the affected person to you or the baby's father. _____
17. Any history of MATERNAL METABOLIC DISORDER? (e.g. Type 1 diabetes, PKU) NO YES
If yes, indicate the disorder. _____
18. Have you, or your husband, had a child with any birth defects not listed above? NO YES
If yes, please describe. _____
19. Have you had three or more spontaneous abortions? NO YES
If yes, please describe. _____
20. Have you had any stillborns? NO YES
If yes, please give cause, if known. _____

GENETIC SCREENING CONTINUED

21. Have you had any medications, street drugs, or alcohol since your last menstrual period? NO YES
(Please list supplements, vitamins, herbs, over the counter drugs, illicit or recreational drugs and alcohol used since your last period.)
If yes, list anything you took, amounts, and when taken. _____

22. Do you or your husband, or any close relative in either of your families, have any birth defects, familial disorders, or chromosomal abnormalities not listed above? NO YES
If yes, indicate the condition and the relationship of the affected person to you or the baby's father. _____

23. Have you or your husband has chromosomal studies done? NO YES
If yes, who, when was it done, and what did the report show? _____

INFECTION HISTORY

1. Have you been exposed to TB (tuberculosis)? NO YES
If yes, please give date and describe. _____
2. Have you had a history of genital herpes? NO YES
If yes, how many episodes per year do you have? _____
If yes, are you on oral suppressive drug therapy? NO YES
3. Has your husband had a history of genital herpes? NO YES
If yes, and he is on oral suppressive drug therapy, please describe. _____
4. Have you had a rash or viral illness since your last menstrual period? NO YES
If yes, please give date and describe. _____
5. Have you had hepatitis: B C ? If yes, when and what treatment have you had? _____
If yes, please give date and describe. _____
6. Have you had any history of a sexually transmitted disease - Gonorrhea, Chlamydia, Condyloma (venereal warts or HPV), or Syphilis? NO YES
If yes, please give date and describe. _____
7. Has your husband ever had a history of a sexually transmitted disease? NO YES
If yes, please give date and describe. _____
8. Do you or your husband do anything in your lifestyles or workplace that puts you at high risk for H.I.V. (A.I.D.S.)? NO YES
If yes, please describe. _____
9. Do you or your husband do anything in your lifestyles or at your workplace that puts you in contact with toxic vapors, chemicals, or drugs? NO YES
If yes, please describe. _____
10. Have you ever been tested for immunity to RUBELLA (German Measles)? NO YES
If yes, please indicate the lab results. IMMUNE NON-IMMUNE DATE IMMUNIZED: _____
11. Have you ever had Varicella Zoster (Chicken Pox)? NO YES
12. Have you ever received the Varicella Zoster immunization? YES NO If YES, WHEN? _____
13. Are you around, or do you own cats? NO YES
A. If yes, have your cats all been tested for Toxoplasmosis? NO YES
B. If your cats were tested, what were the results? NEGATIVE POSITIVE
14. Do you have any history of any infection not listed above? NO YES If YES, please explain: _____

PLEASE LIST ANY DRUG ALLERGIES	LIST REACTION (i.e.- rash, shortness of breath, hives, itching, etc.)

PLEASE LIST ANY FOOD ALLERGIES	LIST REACTION TO THESE FOODS

CURRENT MEDICATIONS	DOSAGE	HOW MANY A DAY	REASON FOR TAKING

Please list over the counter drugs, herbs, homeopathic treatments, vitamins, drugs from out of the country, etc. you are currently taking:

DRUG/TREATMENT	DOSAGE	INDICATION FOR TAKING

IF YOU DRINK ALCOHOLIC BEVERAGES, APPROXIMATELY HOW MUCH AND WHAT DO YOU DRINK PER WEEK?

Have you ever been treated for substance abuse? NO YES **If yes, please fill in information below.**

DATE TREATED	PLACE OF TREATMENT	SUBSTANCE TREATED FOR

Do you feel you need assistance with a drug or alcohol problem now? NO YES

If yes, please describe. _____

IF YOU USE ANY DRUGS SUCH AS COCAINE, MARIJUANA, AMPHETAMINES, DIET DRUGS, STEROIDS, OR ANY OTHER ILLEGAL DRUGS, PLEASE DESCRIBE YOUR USE:

NAME OF DRUG	WHEN USED	HOW OFTEN	LAST TIME USED

DO YOU OR YOUR HUSBAND HAVE ANY FAMILY HISTORY OR CONCERNS NOT PREVIOUSLY MENTIONED ON THIS QUESTIONNAIRE? PLEASE EXPLAIN:

THANK YOU FOR TAKING THE TIME TO COMPLETE YOUR HEALTH HISTORY.