unitedregional
physician group

□ **Dr. Chu**

□ **Dr. Spencer**

□ **Dr. Tran**

Patient Name:____ **DOB**: __________________

Obstetric History Questionnaire

Are you currently pregnant? □ Yes □ No

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

What is your due date if known? ___________________ **What is your blood type?** ________________

Are there any problems with your current pregnancy?

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Prior Pregnancies:

______ Number of total pregnancies

______ Number of pregnancies carried full term (40 weeks)

______ Number of pregnancies delivered prematurely

______ Number of pregnancies continued past 4 ½ months (20 weeks)

______ Number of spontaneous miscarriages

______ Number of tubal pregnancies

______ Number of voluntary abortions

______ Number of multiple births (twins, triplets)

______ Number of living children

Fill in information in table below for each pregnancy (whether the child is living or deceased). Please start with your first one. Also please list under delivery type if forceps or a vacuum were used.

Year	Weeks	Labor Length	Birth wt.	sex	Type of Delivery (Vaginal or Cesarean Section)	Anesthesia

Please list below any complications or comments regarding pregnancies listed above:

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Do you, the father of this baby, or any close relatives have any of the following? <u>If yes, please specify</u> which <u>relative</u>.

			Relative
Thalassemia MCV < 80	□ Yes	□ No	_______________
Neural Tube Defect (Spina Bifida or Anencephaly)	□ Yes	□No	_______________
Congenital Heart Defect	□ Yes	□ No	_______________
Down Syndrome	□ Yes	□ No	_______________
Tay-Sachs	□ Yes	□ No	_______________
Sickle Cell Disease or Trait	□ Yes	□ No	_______________
Hemophilia or Bleeding Problems	□ Yes	□ No	_______________
Muscular Dystrophy (Type________________________)	□ Yes	□ No	_______________

Cystic Fibrosis □ Yes □ No _______________

Canavan Disease □ Yes □ No _______________

Mental Retardation/ Autism/ Learning Disorder □ Yes □ No _______________

Huntington Chorea □ Yes □ No _______________

Other Inherited Genetic or Chromosomal Disorder □ Yes □ No _______________

Maternal Metabolic Disorder (i.e. Insulin-dependent) □ Yes □ No _______________

Patient or Baby's Father had a Child with Birth Defects □ Yes □ No _______________

Recurrent Pregnancy Loss, or Stillbirth □ Yes □ No _______________

Blindness or Deafness □ Yes □ No _______________

Bone or Skeletal Disorder (Dwarfism) □ Yes □ No _______________

Breast, Ovarian or Colon Cancer □ Yes □ No _______________

Kidney Disorder □ Yes □ No _______________

Diabetes □ Yes □ No _______________

Blood Clots or Stroke □ Yes □ No _______________

Have you taken any medication other than PN vitamins since becoming pregnant?

If yes, please list. ____

Have you used any street drugs since becoming pregnant? □ Yes □ No

Any other illness? □ Yes □ No

If yes, what? ____

Anything else that seems to run in the family? □ Yes □ No

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Have you had any exposure to any of the following?

□ Sauna □ Cat Litter □ X-rays □ Hot Tub □ Chemicals □ Fever/ Infections/ Rash □ Electric Blanket

When was your last pap smear? ____

Have you ever had an abnormal pap? If So, When______________________________________

If you have had an abnormal pap, have you ever had any of the following? (Please include date)

COLPOSCOPY__________________ LEEP___________________ CRYO THERAPY_______________

When was your last mammogram?____

When was your last colonoscopy?____

Why did you have one? ____

Have you ever had a bone density scan and if so, when? ____________________________________

Do you have any of the following?

☐Yes	☐No	☐Unsure	Unexplained Fever
☐Yes	☐No	☐Unsure	Vision Problems
☐Yes	☐No	☐Unsure	Hearing Loss
☐Yes	☐No	☐Unsure	Ear Infections (Other than Childhood
☐Yes	☐No	☐Unsure	Sinus Problems
☐Yes	☐No	☐Unsure	Repeated Nosebleeds
☐Yes	☐No	☐Unsure	Long Term Sore Throat
☐Yes	☐No	☐Unsure	Pneumonia
☐Yes	☐No	☐Unsure	Asthma
☐Yes	☐No	☐Unsure	Close Contact with Person with Tuberculosis
☐Yes	☐No	☐Unsure	Tuberculosis Vaccine
☐Yes	☐No	☐Unsure	Positive Tuberculosis Skin Test
☐Yes	☐No	☐Unsure	Unexplained Cough
☐Yes	☐No	☐Unsure	Unexplained Shourtness of Breath
☐Yes	☐No	☐Unsure	Other Lung Problems
☐Yes	☐No	☐Unsure	Heart Murmur
☐Yes	☐No	☐Unsure	Mitral Valve Prolapse
☐Yes	☐No	☐Unsure	Other Heart Problems
☐Yes	☐No	☐Unsure	High Blood Pressure in Pregnancy
☐Yes	☐No	☐Unsure	High Blood Pressure Other
☐Yes	☐No	☐Unsure	Raynaud's Disease, Raynaud's Phenomenon
☐Yes	☐No	☐Unsure	Poor Blood Circulation
☐Yes	☐No	☐Unsure	Severe Nausea and Vomiting in Pregnancy
☐Yes	☐No	☐Unsure	Severe Nausea and Vomiting Before Pregnancy
☐Yes	☐No	☐Unsure	Intestinal Problems
☐Yes	☐No	☐Unsure	Unexplained Recurring Diarrhea
☐Yes	☐No	☐Unsure	Constipation Problems
☐Yes	☐No	☐Unsure	Heartburn, Reflux
☐Yes	☐No	☐Unsure	Hepatitis, Yellow Jaundice, Hepatitis B, C
☐Yes	☐No	☐Unsure	Liver Problems
☐Yes	☐No	☐Unsure	Bladder or Kidney Infections
☐Yes	☐No	☐Unsure	Kidney Stones
☐Yes	☐No	☐Unsure	Problem with Urine
☐Yes	☐No	☐Unsure	Menstral Problems
☐Yes	☐No	☐Unsure	Infertility, Difficulty Getting Pregnant
☐Yes	☐No	☐Unsure	Infertility Treatment of Assistied Reproductive Technology
☐Yes	☐No	☐Unsure	Vaginal Infections

☐Yes	☐No	☐ Unsure	Herpes or Apartner with Herpes
☐Yes	☐No	☐ Unsure	Sexually Transmitted Disease
☐Yes	☐No	☐ Unsure	Pelvic Inflammatory Disease
☐Yes	☐No	☐ Unsure	Gonorrhea
☐Yes	☐No	☐ Unsure	Chlamydia
☐Yes	☐No	☐ Unsure	Syphilis
☐Yes	☐No	☐ Unsure	Genital Warts
☐Yes	☐No	☐ Unsure	HIV Infection, AIDS or A Partner with HIV/AIDS
☐Yes	☐No	☐ Unsure	Abnormal Pap Smears
☐Yes	☐No	☐ Unsure	Diabetes
☐Yes	☐No	☐ Unsure	Thyroid Problems
☐Yes	☐No	☐ Unsure	Other Hormone Problems
☐Yes	☐No	☐ Unsure	Epilepsy, Seizure Disorder
☐Yes	☐No	☐ Unsure	Unexplained Drowsiness
☐Yes	☐No	☐ Unsure	Migraine/ Cluster Headaches
☐Yes	☐No	☐ Unsure	Other Recurring Headaches
☐Yes	☐No	☐ Unsure	Depression (Post Partum; Major Depression)
☐Yes	☐No	☐ Unsure	Mood Disorder/ Psychiatric/ Emotional Problems
☐Yes	☐No	☐ Unsure	Skin Problems
☐Yes	☐No	☐ Unsure	Unexplained Hair Loss
☐Yes	☐No	☐ Unsure	Arthritis/ Joint Pain
☐Yes	☐No	☐ Unsure	Lupus
☐Yes	☐No	☐ Unsure	Rheumatic Fever
☐Yes	☐No	☐ Unsure	Blood Transfusions
☐Yes	☐No	☐ Unsure	Bleeding Tendency
☐Yes	☐No	☐ Unsure	Blood Clots, Thrombophlebitis
☐Yes	☐No	☐ Unsure	Rh Sensitized

Please list any other conditions not named above:____

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