

# Initial OB Health Questionnaire

This health questionnaire is intended for use by your obstetric clinicians in developing a care plan during your pregnancy. It addresses health and social issues concerning you and your partner and will assist our clinical staff in helping you prepare for parenthood. **Please answer all questions as thoroughly as possible and bring the completed questionnaire with you to your initial obstetric appointment.** At that time, your clinician will review this form with you and address any concerns you may have regarding your pregnancy. You are welcome to bring your partner with you to all obstetric appointments.

## PATIENT

Name: \_\_\_\_\_

Date: \_\_\_\_\_

Address: \_\_\_\_\_

Telephone #: \_\_\_\_\_ (H) \_\_\_\_\_ (W)

Cell #: \_\_\_\_\_ Marital Status: \_\_\_\_\_

Place of Birth: \_\_\_\_\_

Occupation: \_\_\_\_\_

Employer: \_\_\_\_\_

Work Hours/Days: \_\_\_\_\_

Are you a recent (w/in 5 yrs) immigrant? \_\_\_\_\_

Number of persons in your household? \_\_\_\_\_

## ALLERGIES & MEDICATIONS:

Are you allergic to any **MEDICATIONS**?  **None** If yes, please specify medications and reactions below:

Do you have any **OTHER ALLERGIES**?  **None** If yes, please specify allergies and reactions below:

Are you **currently taking any medications**?  **None** If yes, please specify below:

Medication	Dose	Frequency

Medication	Dose	Frequency

Medication	Dose	Frequency

## MENSTRUAL HISTORY:

What was the first day of your last menstrual period? \_\_\_\_\_ Was it normal?  no  yes

If not, when was your last normal period? \_\_\_\_\_ How often do you menstruate? \_\_\_\_\_

How many days do your menstrual periods usually last? \_\_\_\_\_

Date of conception (if known): \_\_\_\_\_

Type of birth control last used: \_\_\_\_\_ Date last used: \_\_\_\_\_

**For Clinician Use**  
**PAS LABEL**

Form Version: 11.07

## PARTNER

Name: \_\_\_\_\_

Address: \_\_\_\_\_

Telephone # (H): \_\_\_\_\_ (W) \_\_\_\_\_

Occupation: \_\_\_\_\_

Employer: \_\_\_\_\_

Emergency Contact: \_\_\_\_\_

Telephone #: \_\_\_\_\_

Relationship to patient: \_\_\_\_\_

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EDC by LMP:

EDC by U/S:

Adjusted EDC:

## ENVIRONMENTAL EXPOSURE (for current pregnancy):

Have you taken any medication since your last period?  no  yes If yes, what? \_\_\_\_\_

Have you been exposed to any chemicals?  no  yes If yes, what? \_\_\_\_\_

Have you been exposed to any x-rays, lead or viral infection since your last period?  no  yes

If yes, explain: \_\_\_\_\_

Have you been exposed to any occupational or work-related risks?  no  yes If yes, explain: \_\_\_\_\_

What pets do you have in your home? \_\_\_\_\_

How do you feel about this pregnancy? \_\_\_\_\_

Is your partner/family supportive of this pregnancy? \_\_\_\_\_

**GENETIC BACKGROUND:**

Your race/heritage may affect your baby's risk for certain inherited disorders. Please check all that apply.

**Your race/heritage:** \_\_\_ African/American \_\_\_ Asian \_\_\_ Caucasian \_\_\_ Eastern-European Jewish  
 \_\_\_ French-Canadian \_\_\_ Hispanic \_\_\_ Mediterranean \_\_\_ Native American \_\_\_ Other (please specify) \_\_\_\_\_

**Father of baby race/heritage:** \_\_\_ African/American \_\_\_ Asian \_\_\_ Caucasian \_\_\_ Eastern-European Jewish  
 \_\_\_ French-Canadian \_\_\_ Hispanic \_\_\_ Mediterranean \_\_\_ Native American \_\_\_ Other (please specify) \_\_\_\_\_

**Age of baby's father:** \_\_\_\_\_

Please indicate if the following applies to you or your family. Check unshaded area only.

GENETICS	Self	Your family member (Who?)	Biological father of baby	Father of baby family member	EXPLANATION
History of child with birth defect					
Family member with birth defect					
Neural tube defect, spina bifida, anencephaly					
Carrier of genetic disease					
Chromosomal problems					
Hemophilia					
Cystic fibrosis					
G6PD deficiency					
Sickle cell anemia/sickle cell trait					
Inborn error of metabolism (special diet as a child?)					
Mental retardation (diagnosis?)					
Muscular dystrophy					
Polycystic kidneys					
Tay Sachs Disease					
Huntington's chorea					
You are related to the father of the baby by blood (relationship?)					

**REVIEW OF SYSTEMS: Check if you currently have problems with:**

- |   |   |   |
|---|---|---|
| <input type="checkbox"/> fatigue                    | <input type="checkbox"/> persistent cough           | <input type="checkbox"/> back pain                  |
| <input type="checkbox"/> weight loss                | <input type="checkbox"/> shortness of breath        | <input type="checkbox"/> headaches                  |
| <input type="checkbox"/> weight gain                | <input type="checkbox"/> wheezing                   | <input type="checkbox"/> fainting/dizziness/balance |
| <input type="checkbox"/> easy bruising              | <input type="checkbox"/> difficulty breathing       | <input type="checkbox"/> anxiety                    |
| <input type="checkbox"/> enlarged glands or lumps   | <input type="checkbox"/> indigestion or nausea      | <input type="checkbox"/> depression                 |
| <input type="checkbox"/> environmental allergies    | <input type="checkbox"/> abdominal pain or bloating | <input type="checkbox"/> memory loss                |
| <input type="checkbox"/> hot flashes                | <input type="checkbox"/> constipation               | <input type="checkbox"/> trouble sleeping           |
| <input type="checkbox"/> heat or cold intolerance   | <input type="checkbox"/> diarrhea                   | <input type="checkbox"/> varicose veins             |
| <input type="checkbox"/> excess hair growth or loss | <input type="checkbox"/> painful urination          | <input type="checkbox"/> breast pain                |
| <input type="checkbox"/> skin                       | <input type="checkbox"/> involuntary loss of urine  | <input type="checkbox"/> breast discharge           |
| <input type="checkbox"/> moles                      | <input type="checkbox"/> abnormal vaginal discharge | <input type="checkbox"/> breast lump                |
| <input type="checkbox"/> chest pain                 | <input type="checkbox"/> muscle or joint pain       | Other _____   |

**MEDICAL HISTORY – FAMILY MEDICAL HISTORY:**

	SELF	Family member- Who?	Father of Baby (biological)	EXPLANATION
<b>BLOOD/CIRCULATORY</b>				
Blood type if known and Rh factor				
Anemia (iron, B12, folic acid deficiency)				
Varicose veins or phlebitis				
Blood clots in legs or lungs				
Rh sensitization				
History of transfusions				
Problems with blood clotting or easy bruising				
High blood pressure				
<b>ENDOCRINE</b>				
High blood sugar (diabetes)				
Gland problems (thyroid, adrenal, pituitary)				
<b>RESPIRATORY</b>				
Asthma (childhood/adult)				
<b>CARDIAC</b>				
Heart murmur				
Rheumatic fever				
Mitral valve prolapse				
Heart attack				
Arrhythmia or irregular heartbeat				
<b>NEUROLOGIC/PSYCHIATRIC</b>				
Seizure				
Stroke				
Neurologic problem				
Migraine headaches				
Emotional problems – please describe				
<b>URINARY TRACT</b>				
Urinary tract or Kidney infections				
Kidney stones				
<b>SKELETAL</b>				
Arthritis				
Pelvic/back fractures				
<b>GASTROINTESTINAL</b>				
Irritable bowel syndrome				
Chron's disease, ulcerative colitis				
Chronic constipation				
History of hepatitis, pancreatitis				
Gallstones				
<b>SYSTEMIC</b>				
Lupus/connective tissue disease				
Sarcoidosis				
Rheumatoid arthritis				
Cancer (type)				
<b>GYNECOLOGIC</b>				
Infertility (cause if known)				
Abnormal pap smear				
Cryo/cone/laser/LEEP				
DES exposure				
Uterine abnormality				
Fibroids				
History of pelvic inflammatory disease				
<b>INFECTIONS</b>				
Chickenpox				
Tuberculosis				
Genital herpes				
Syphilis				
Gonorrhea or Chlamydia				
Would you like to be tested for HIV ?				



**For Clinician Use**

G \_\_\_\_\_ P \_\_\_\_\_  
A \_\_\_\_\_ L \_\_\_\_\_

**OBSTETRICAL HISTORY:**

Total number of pregnancies \_\_\_\_\_  
(Include current pregnancy, miscarriages, abortions and ectopic pregnancies)

<b>PREGNANCY</b>	<b>FIRST</b>	<b>SECOND</b>	<b>THIRD</b>	<b>FOURTH</b>	<b>FIFTH</b>	<b>SIXTH</b>
<i>Month/Year</i>	<i>Indicate the date/month/year of each pregnancy, in the corresponding column</i>					
Full-term birth						
Premature birth						
Multiple Birth (twins, etc.)						
Miscarriage						
Ectopic pregnancy						
Induced abortion						
<b>PREGNANCY COMPLICATIONS</b>	<i>Place a check under the corresponding pregnancy if you experienced any of the following</i>					
NONE						
High blood pressure/Toxemia						
Bleeding or severe anemia						
Vomiting (excessive)						
Gestational Diabetes						
Bladder or Kidney Infection						
Treatment for premature labor						

<b>LABOR AND DELIVERY</b>	<b>FIRST</b>	<b>SECOND</b>	<b>THIRD</b>	<b>FOURTH</b>	<b>FIFTH</b>	<b>SIXTH</b>
Type of Delivery:	<i>Place a check in the box that describes the delivery for each pregnancy</i>					
Vaginal						
Vaginal with Forceps						
Vaginal with Vacuum						
Cesarean Section						
	<i>Fill in the information that applies to each birth under the appropriate column.</i>					
Gestational age (# Weeks Pregnant)						
Birth weight						
Female/male						
Breast/bottle fed						
Current health status of child						
Induced labor						
Hours of labor						
Anesthesia used						
Place of Birth						

<b>COMPLICATIONS</b>	<b>FIRST</b>	<b>SECOND</b>	<b>THIRD</b>	<b>FOURTH</b>	<b>FIFTH</b>	<b>SIXTH</b>
<b>LABOR &amp; DELIVERY</b> (e.g., difficulty delivering baby's shoulders, anesthesia issues, episiotomy/laceration)						
NONE						
Other – please describe						
<b>POSTPARTUM</b>						
NONE						
Breastfeeding problems						
Postpartum depression						
Other – please describe						
<b>NEWBORN</b>						
NONE						
Infection						
Other – please describe						