OB Medical History Questionnaire

Name____ DOB ________________ Date__________________________

Have you had ANY prenatal care for this pregnancy? ____

Please list ANY/ALL ultrasounds, ER visits, doctors' visits, or labs for this pregnancy and where.

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Please list ANY ER visits you may have had in the last 6 months. _______________________________

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CURRENT MEDICATIONS (include vitamins, mineral and herbs)

Name of Medication	Dosage (mg)	Number of Daily Doses	Purpose (medical condition treated)	Prescribing Physician

<u>MEDICAL HISTORY</u> (check all medical problems you currently have):

□_ Abnormal Pap smear or Cervical Disease □_ Cancer □_ Diabetes □_ Stroke □_ Hepatitis
□_ Thromboembolic Disease (clots) _ Hypertension□_ Meningitis □_ Anemia □_ Heart Disease
□_ Irritable Bowel Disease _ Asthma □_ Epilepsy □_ Endometriosis _ Rheumatic Fever
_ Abnormal Mammogram _ Sexually-Transmitted Diseases ____________________
□_ Gastroesophageal Reflux _ Other____ □_ **None**

<u>GYN HISTORY- please check all that apply</u>

Periods**:** _ Normal □ _ Irregular _ Normal Blood Loss □_ Heavy Blood Loss □
_ Pain _ Menopausal _ Prolonged Bleeding _ Passage of Large Clots □
_ Bleeding After Sex or Between Periods

How often do you have a period? □ _ Monthly□ _ every 28 days□ _ other____________________

Date of last menstrual period ____

If you are pregnant have you had an Ultrasound? _ Y _ N Date________________ Facility____________

Age when menstrual periods began: __________________ years old.

Sexual Activity □_ Active □_ Not Currently Active □_ Single Partner □_ Other ________________

Date of Last Pap Smear ___ ____________________Was it normal? ____________________________

Date of Last Mammogram ______________________Was it normal? ____________________________

Date of Abnormal Pap Smear______________________________________ □_Never

Infertility? _ Yes _ No Polycystic Ovarian Syndrome? _ Yes _ No

What were you using for contraception? ____ _ **None**

Positive Urine Pregnancy Test? _ Yes _ No Date of first home or doctor's office pregnancy test_______

ALLERGIES (Please List)

____ ____ _ **None**

OB HISTORY

Total Pregnancies (incl. this one)	
Total Living Children	

PREGNANCY/DELIVERY

	Preg #1	**Preg #2**	**Preg #3**	**Preg #4**
Date of Delivery				
Gest. Age (weeks)				
Length of Labor				
Birth Weight				
Sex (M/F)				
Type of Delivery				
Anesthesia				
Place of Delivery				
Preterm Labor (y/n)				
Physician				
Complications				
Comments				

SURGICAL HISTORY

Month and Year	**Surgery**

HOSPITALIZATIONS

Month and Year	**Reason**

FAMILY HISTORY

Family Member	**Status: alive or deceased**	**Age**	**Indicate any medical problems: cancer, diabetes, stroke, high blood pressure, kidney disease, birth defects, etc.**
Father			
Mother			
Paternal Grand Father			
Paternal Grand Mother			
Maternal Grand Father			
Maternal Grand Mother			
Paternal Uncle			
Paternal Aunt			
Maternal Uncle			
Maternal Aunt			
Brother (How many)			
Sister (How many)			
Son			
Daughter			

SOCIAL HISTORY

Do you smoke? _ No	_ Yes Packs Per Day______________ Years__________
Illegal drug use? _ No	_ Yes Current Use__________________ Past Use___________________
Exercise? _ No	_ Yes Type______________________ How Often______________
Caffeine? _ No	_ Yes Type______________________ Daily Amount______________
Alcohol? _ No	_ Yes Type_____________ How Often ___________ Years__________
Occupation?	