

Oakdale OB/GYN

New OB Patient Questionnaire

Date: _____

Patient name: _____

Date of birth: _____

Date of Pregnancy Test:
First day of your last menstrual period:
Are your cycles regular? Yes No
Pre pregnancy weight:
Date of last tetanus/Tdap:
Will you be 35 years of age or older at your due date? Yes No
Is your family complete after this baby? Yes No
What is your post partum birth control plan?

SOCIAL HISTORY				
Marital status:				
Name of spouse or partner:				
Your race:				
Race of the baby's father:				
Your occupation:				
How much do you exercise?	None	1xweek	1-3x week	4 or more x week
Do you smoke cigarettes?	Never	Quit	Yes	How many cigarettes per day?
How much alcohol do you drink?	amount pre pregnancy:		amount now:	
Do you use illegal drugs?	Yes	No		
Exposure to lead or chemicals:	Yes	No		
Do you drink caffeine?	Yes	No		
Exposure to radiation?	Yes	No		
Exposure to Infections (hospital, teaching, daycare):	Yes	No		
Do you have cats?	Yes	No		
Live with someone with TB (tuberculosis)?	Yes	No		
Do you have family support at home?	Yes	No		
Do you have housing concerns?	Yes	No		
Do you have any cultural or religious needs?	Yes	No		

MEDICAL HISTORY	NO	YES/WHEN
Herpes		
Diabetes		
High blood pressure		
Heart disease		
Chicken pox		
Autoimmune disease		
Kidney disease/ UTI		
Mental illness		

Hepatitis / Liver disease		
MEDICAL HISTORY (continued)	NO	YES/WHEN
DVT – PE (blood clots)		
Thyroid disease		
Trauma		
Domestic violence		
Chronic back pain		
Anemia		
Asthma		
Infertility		
Eating disorder		
Anesthetic reactions		

GENETIC HISTORY – Please consider family history for you and the baby’s father.					
Diabetes Yes No					
DVT – PE (blood clots)		Yes	No		
Neural tub defect (spina bifida)		Yes	No		
Canavan Disease (Jewish)		Yes	No		
Congenital Heart Disease		Yes	No		
Down Syndrome Yes No					
Recurrent pregnancy loss or stillbirth. Yes No					
Tay-Sachs (Jewish, Cajun, French Canadian) Yes No					
Sickle Cell Disease or Trait		Yes	No		
Cystic Fibrosis		Yes	No		
Maternal metabolic disorder Yes No					
Mental retardation/Autism		Yes	No	Was the person tested for Fragile X	
				Yes	No
Other inherited genetic or chromosomal disorders.		Yes	No		
Hemophilia Yes No					
Muscular Dystrophy		Yes	No		
Other birth defects not listed.		Yes	No	If yes, please explain.	

HEALTH MAINTENANCE AND SCREENING TESTS & WHEN THEY WERE <u>LAST</u> PERFORMED					
Pap Test Date:					
Any abnormal Pap results:		Yes	No		
If abnormal Pap result please list the YEAR of abnormal result:					
If abnormal Pap how was it treated?					
Mammogram	Date:	Any abnormal:	Yes	No	
Cholesterol	Date:	Normal	High		
Diabetes Screening	Date:	Normal	High		

Thyroid Screening	Date:	Low	Normal	High
Colonoscopy/ Sigmoidoscopy	Date:	Any abnormal:		Yes No

OB HISTORY						
Total number of Pregnancies				Tubal Pregnancies		
Living (birth) children				Miscarriages		
Number of full term deliveries				Abortions		
Number of premature deliveries						
Birth Date	Weeks Gestation	Baby's Weight	Baby's Sex	Type of Delivery	Physician or Hospital	Complications

CURRENT MEDICATIONS - Prescription and over the counter medications including vitamins, and herbal medications.			
Medication	Dose	Medication	Dose

ALLERGIES (food, medication, other)			
List allergy	List reaction	List allergy	List reaction

Please list all past surgeries			
Surgery	Date	Surgery	Date