

# Obstetrical Health History Questionnaire:

Name \_\_\_\_\_ Date of birth \_\_\_\_\_

Address \_\_\_\_\_

Local phone number \_\_\_\_\_ Alternative phone number \_\_\_\_\_

## Special Communication Needs:

Language preference:

If 'yes' to any of the questions below, how can we assist?

Visual impairment  Yes  No

Hearing impairment  Yes  No

Speech impairment  Yes  No

Cognitive impairment  Yes  No

Sensory impairment  Yes  No

Are there any religious or cultural factors that you would like us to take into account when planning your healthcare?

## Marital Status

Single  Married/Life Partner *Years Together* \_\_\_\_\_  Divorced  Widowed

## Parental Health History

	Patient/Mother	Husband or Partner/Father
Country of Birth:		
Race:		
Religion		
Education:		
Occupation:		
Significant Family Disease:		

**Mother only** Pre-pregnancy Weight: \_\_\_\_\_ Months Attempting Pregnancy: \_\_\_\_\_

**Father only** Age: \_\_\_\_\_ Height: \_\_\_\_\_ Weight: \_\_\_\_\_

## Personal Health History

Please check past or current problems or conditions

<input type="checkbox"/> Kidney Disease/UTI	<input type="checkbox"/> DES Exposure	<input type="checkbox"/> Abdominal Pain
<input type="checkbox"/> Heart Disease	<input type="checkbox"/> Thyroid Dysfunction	<input type="checkbox"/> Urinary Complaints
<input type="checkbox"/> Mitral Valve Prolapse	<input type="checkbox"/> Phlebitis/Varicose Veins	<input type="checkbox"/> German Measles
<input type="checkbox"/> Hypertension	<input type="checkbox"/> Blood Transfusion	<input type="checkbox"/> Other Virus: _____
<input type="checkbox"/> Rheumatic Fever	<input type="checkbox"/> RH Sensitivity	<input type="checkbox"/> Radiation Specify: _____
<input type="checkbox"/> Asthma	<input type="checkbox"/> Vomiting	<input type="checkbox"/> Accidents
<input type="checkbox"/> Tuberculosis	<input type="checkbox"/> Constipation	<input type="checkbox"/> Chemical/Toxin Exposure
<input type="checkbox"/> Hepatitis/Liver Disease	<input type="checkbox"/> Headache	<input type="checkbox"/> Other: _____
<input type="checkbox"/> Abnormal Uterus	<input type="checkbox"/> Rash	

**Menstruation:** First Day of Last Period: \_\_\_\_\_ Length: \_\_\_\_\_ Occurs Every \_\_\_\_\_ Days Normal?  Yes  No

## Obstetrical Health History

Total Pregnancies:		Full Term:		Premature:		Living:			
Spontaneous Miscarriages:		Ectopic:		Multi-births:		Elective Abortions:			
Date of Delivery	Place of Delivery	Weeks Gestation	Gender	Hours in Labor	Weight	Type of Delivery	Anesthesia	Comments Mother	Complications Baby

List Surgeries:

## Social History:

**Live here year round?**     Yes     No    If no, Part time location: \_\_\_\_\_

**Tobacco use:**     Never     Quit (when) \_\_\_\_\_     Current smoker: Packs/day, how many years \_\_\_\_\_

**Do you have pets?**     Yes     No    Type(s): \_\_\_\_\_

**Alcohol use:**     No     Yes    If yes how many drinks/how often \_\_\_\_\_

**Illicit Drug use** (including marijuana, cocaine, steroids):     Never     Past     Current  
Describe: \_\_\_\_\_

## Additional Health History

<b>Please answer the following questions:</b>	<b>YES</b>	<b>NO</b>
Are you of Asian, Pacific Island or Alaskan Eskimo Decent?	<input type="checkbox"/>	<input type="checkbox"/>
Were you born in Haiti or Sub-Saharan Africa?	<input type="checkbox"/>	<input type="checkbox"/>
Do you have a history of acute or chronic liver disease?	<input type="checkbox"/>	<input type="checkbox"/>
Do you work in or receive treatment in a hemodialysis unit?	<input type="checkbox"/>	<input type="checkbox"/>
Do you have a history of rejection as a blood donor?	<input type="checkbox"/>	<input type="checkbox"/>
Have you or your partner had a blood transfusion?	<input type="checkbox"/>	<input type="checkbox"/>
Do you have occupational exposure to blood in a medicodental setting?	<input type="checkbox"/>	<input type="checkbox"/>
Do you have household contact with a hepatitis carrier or hemodialysis patient?	<input type="checkbox"/>	<input type="checkbox"/>
In the last five years, have you had a sexual relationship with a partner that may have had a sexually transmitted disease?	<input type="checkbox"/>	<input type="checkbox"/>
Have you had more than one sexual partner in the past ten years?	<input type="checkbox"/>	<input type="checkbox"/>
Have you or your partner used injectable "street drugs"?	<input type="checkbox"/>	<input type="checkbox"/>
Do you have a bisexual partner?	<input type="checkbox"/>	<input type="checkbox"/>
Do you have any parents or siblings with diabetes?	<input type="checkbox"/>	<input type="checkbox"/>
Have you had a child with a birth weight of 9lbs or more?	<input type="checkbox"/>	<input type="checkbox"/>
Do you have a history of Glycosuria (sugar in urine)?	<input type="checkbox"/>	<input type="checkbox"/>
Do you or the baby's father have a family history of any of the following (please check any that apply) <ul style="list-style-type: none"> <li><input type="checkbox"/> Down's Syndrome</li> <li><input type="checkbox"/> A chromosomal abnormality</li> <li><input type="checkbox"/> Neural Tube Defect (i.e., spina bifida, anencephaly, or hydrocephalus)</li> <li><input type="checkbox"/> Hemophilia</li> <li><input type="checkbox"/> Muscular Dystrophy</li> <li><input type="checkbox"/> Cystic Fibrosis</li> <li><input type="checkbox"/> Huntington's Chorea</li> </ul>	<input type="checkbox"/>	<input type="checkbox"/>
Have you or the baby's father had a child born dead or alive with a birth defect not mentioned above?	<input type="checkbox"/>	<input type="checkbox"/>
Do you or the baby's father have any close relatives with mental retardation? If yes, relation _____	<input type="checkbox"/>	<input type="checkbox"/>
Are you and the baby's father first cousins or more closely related?	<input type="checkbox"/>	<input type="checkbox"/>
Have you or the baby's father had a chromosomal study? If yes, who and what were the results? _____	<input type="checkbox"/>	<input type="checkbox"/>
Are you or the baby's father of Jewish ancestry? If yes, have either of you been screened for Tay-Sachs disease <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, what were the results? _____	<input type="checkbox"/>	<input type="checkbox"/>

### Additional Health History (cont'd)

Are you or the baby's father of African ancestry? If yes, have either of you been screened for the sickle cell trait? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, what were the results? _____	<input type="checkbox"/>	<input type="checkbox"/>
Are you or the baby's father of Italian, Greek, or Mediterranean ancestry? If yes, have either of you been screened for B-Thalassemia? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, what were the results? _____	<input type="checkbox"/>	<input type="checkbox"/>
Are you or the baby's father of Philippine or Southeast Asian ancestry? If yes, have either of you been screened for the A-Thalassemia? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, what were the results? _____	<input type="checkbox"/>	<input type="checkbox"/>
<i>Excluding Iron and Vitamins</i> , have you taken any medications or recreational drugs since being pregnant and/or since your last menstrual period?	<input type="checkbox"/>	<input type="checkbox"/>
<b>If yes, please list the medications and the time taken during pregnancy</b> <input type="checkbox"/> _____ <input type="checkbox"/> _____ <input type="checkbox"/> _____ <input type="checkbox"/> _____		

### Allergies: Please list any allergies to medications , foods, or materials (including latex)

Name	Symptom/Reaction

### Additional Providers:

Primary Care Provider	Other
Name: _____	Name: _____
Phone: _____ Last Seen: _____	Phone: _____ Last Seen: _____

Patient/Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_