New OB Questionnaire - OB/Gyn Downers Grove

Name: _____ Date:_____

Home#_____ Cell#_____ Work #_____

MEDICATION HISTORY

ALLERGIES: **Latex?** NO YES **Shellfish?** NO YES

Medications? NO YES **If yes, list below with reaction**

Medication: _____ Reaction: _____

_____ _____

_____ _____

_____ _____

Medications you are currently taking or have taken *since you have been pregnant*:

Medication	Strength	For how long
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Pharmacy name/location _____

Phone # _____

MENSTRUAL HISTORY

When was the first day of your last period?_____

How old were you when you got your first period?_____

You get your period every_____ days. It lasts for _____ days.

When was the last time you used birth control pills, ring, patches or shot? _____

Abnormal Pap history: Y N Date_____ Results_____

Treatment if abnormal _____

PREGNANCY HISTORY

(please include all births, stillbirths, miscarriages and abortions)

	Date of birth	Sex	Weight	# wks. preg	Hrs. in labor	Delivery type	Name of Baby, Any problems or complications with pregnancy or delivery
1							
2							
3							
4							
5							
6							
7							

GENETIC SCREEN

	Y	N	Relation to you		Y	N	Relation to you
Autism				Birth Defects			
Congenital Heart				Cystic Fibrosis			
Down Syndrome				Genetic Disorder			
Hemophelia				Huntington's Chorea			
Jehovah's Witness				Metabolic Disorder			
Mental Retardation				Neural Tube Defect			
Muscular Dystrophy				Sickle Cell			
Previous Stillbirth				Thallasemia			
Tay Sachs				Other			

HISTORY SINCE YOU HAVE BEEN PREGNANT

X		Comments/explanation
	Abdominal Pain	
	Drug Exposure	
	Headaches	
	Measles	
	Swelling	
	Vaginal Bleeding	
	X-ray exposure	
	Cold or Flu	
	Fever	
	Industrial Toxin Exposure	
	Nausea/vomiting	
	Urinary problems	
	Vaginal Discharge	
	Other	

MEDICAL HISTORY

X all that apply and give details in comments section

X		COMMENT	X		COMMENT
	Acne			Diabetes	
	Anemia			HSV (Herpes Simplex)	
	Anxiety			Irritable Bowel	
	Asthma			Infectious Disease	
	Atrial Fibrillation			Kidney Disease	
	Blood Disorder			Learning Disability	
	Cancer			Lung Disease	
	Congestive Heart Failure			MRSA	
	Coronary Artery Disease			Twins, triplets, etc	
	Depression			Mitral Valve Prolapse	
	Headaches			Nervous/Mental disorder	
	Genito-urinary Disease			Obesity	
	Reflux			Osteoarthritis	
	GI Disorder			Osteopenia	
	Heart Disease			Osteoporosis	
	Hemorrhoids			Rheumatoid Arthritis	
	High Blood Pressure			Seizures	
	Hormone Disorder			Sleep Apnea	
	Hyperthyroid			Stroke	
	Hypothyroid			Toxoplasmosis	
	Other – please list				

SURGICAL HISTORY

PROCEDURE	DATE	COMMENTS	PROCEDURE	DATE	COMMENTS
Angioplasty			D&C		
Appendectomy			Gall Bladder		
Back/Spine			Glaucoma		
CABG			Hemorrhoid		
Cataract			Skin		
Colonoscopy			Tonsils		
C-Section			Tubes Tied		
Other			Other		

Have you ever had a blood transfusion? NO YES

If yes, when?_____

SOCIAL HISTORY

Tobacco Use: Never used _____ Quit _____ Date _____

Yes:_____ Amount/day _____ For how long? _____

Chewing Tobacco Never used _____ Quit _____ Date _____

Alcohol Use: No_____ Yes _____ How much/frequency _____

Drug Use: No _____ Quit/date _____ Type _____

Yes _____ Type/frequency _____

YOUR FAMILY HISTORY

FATHER, MOTHER, BROTHERS OR SISTERS with any of the following:

Disease	Relation to you	Disease	Relation to you
Genetic Dis.		Kidney Dis.	
Birth Defects		High Blood Pressure	
Twins or more		Cancer if Y type	
Heart Disease		Hormone Dis.	
Anxiety or Depression		Diabetes	
Asthma or Lung Dis.		Seizure Disorder	
Genito-Urinary Dis		Mental Disorder	
GI Dis.		Infectious Dis.	
Blood Dis.		Other	