Anne B. Brown, M.D.
Jane D. Allen, M.D.
Cathleen S. Mills, M.D.
Gillian A. Jacob, M.D.
Diane P. Barrett, M.D,

Date: ______________

OBSTETRICAL QUESTIONNAIRE

Patient Name: _________________________________ Age: ______ Date of Birth: _________
Pharmacy: ____

MEDICATIONS (including over-the-counter, herbals, supplements):

Name Of Drug	Dosage	How Often?

ALLERGIES:

Name Of Drug	Reaction

PAST OBSTETRICAL HISTORY:

No.	Date	Sex	Wt.	Duration of Pregnancy	Duration of Labor	Type of Delivery	Whom/ Where Delivered	Anesthesia	Complications

GYNECOLOGICAL HISTORY:

Age Menstrual Period Began: ________ Last Menstrual Period: ___________ Last Pap Smear: _________

Last Mammogram: __________ Cycle Frequency: __________ Duration (# of days): ________ Type of Birth Control: _________

Pre-Pregnancy Weight: _________

MEDICAL HISTORY:

	Pre-pregnancy amount/packs per day	Pregnant amount/packs per day	# of years of use
Tobacco			
Alcohol			
Caffeine			
Recreational Drugs			

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MEDICAL HISTORY CONT.:

1. Diabetes	Yes	No
2. Hypertension	Yes	No
3. Heart Disease	Yes	No
4. Autoimmune Disorder	Yes	No
5. Kidney Disease/UTI	Yes	No
6. Neurologic/Epilepsy	Yes	No
7. Psychiatric	Yes	No
8. Depression/Postpartum	Yes	No
9. Hepatitis/Liver Disease	Yes	No
10. Varicosities/Phlebitis	Yes	No
11. Thyroid Disfunction	Yes	No
12. Trauma/Violence	Yes	No
13. Blood Transfusions	Yes	No
14. D (Rh) Sensitive	Yes	No
15. Varicella (chicken pox)	Yes	No
16. Pulmonary (TB, Asthma)	Yes	No
17. Seasonal Allergies	Yes	No
18. Drug/Latex Allergies	Yes	No
19. Breast Problems	Yes	No
20. GYN surgery (List below)	Yes	No
21. Operation/hosp. (List below)	Yes	No
22. Anesthetic Complications	Yes	No
23. History of abnormal PAP	Yes	No
24. Uterine Anomaly	Yes	No
25. Infertility	Yes	No
26. ART Treatment	Yes	No
27. Relevant History	Yes	No
28. Cats in the home	Yes	No
29. History of MRSA	Yes	No

INFECTION HISTORY:

1. Live with someone with TB or exposed to TB	Yes	No
2. Patient or partner has history of genital herpes (Please circle: Patient or Partner)	Yes	No
3. Rash or viral illness since last menstrual period	Yes	No
4. Hepatits B or C (Please circle which type)	Yes	No
5. Circle if history of any of the following:	Yes	No

HPV Gonorrhea HIV Chlamydia Syphilis

Past Medical History	Date

Past Surgical History	Date

Family History of Disease	Date

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GENETIC COUNSELING/TERATOLOGY COUNSELING:

Patient Name: ____ Date: _________________________

Father of Baby's Name: ____________________________________ Phone Number: _________________

1. Patient's aged 36 or older as of estimated date of delivery. Yes No
2. Thalassemia (Italian, Greek, Mediterranean or Asian background) Yes No
3. Neural Tube Defects (meningomyelocele, spina bifida or anencephaly) Yes No
4. Congenital Heart Defect Yes No
5. Down syndrome Yes No
6. Tay Sachs (Ashkenazi Jewish, Cajun or French Canadian) Yes No
7. Canavan Disease (Ashkenazi Jewish) Yes No
8. Familial dysautonomia (Ashkenazi Jewish) Yes No
9. Sickle Cell disease or trait (African) Yes No
10. Hemophilia or other blood disorders Yes No
11. Muscular Dystrophy Yes No
12. Cystic Fibrosis Yes No
13. Huntington's disease Yes No
14. Intellectual disability / Autism Yes No
15. Other inherited genetic or chromosomal disorder Yes No
16. Maternal metabolic disorder (e.g.: Type 1 Diabetes, PKU) Yes No
17. Patient or baby's father had a child with birth defects not listed above Yes No
18. Recurrent pregnancy loss of a stillbirth Yes No
19. Medications (including supplements, vitamins, herbs, or OTC drugs, or
    Illicit/Recreational Drugs, alcohol since LMP Yes No
    If yes, Agent and strength.dosage.

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