CAPITAL WOMEN'S CARE

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,
Danielle M. Austin, M.D.

Date: _____

OBSTETRICAL QUESTIONNAIRE

Patient Name: _____ Age: _____ Date of Birth: _____
Pharmacy: _____

Would you like a chaperone during your intimate exam today? Please circle: Yes No

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			

CAPITAL WOMEN'S CARE

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,
Danielle M. Austin, M.D.

Patient Name: _____ **DOB:** ___/___/___

MEDICAL HISTORY CONT.:

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

CAPITAL WOMEN'S CARE

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,
Danielle M. Austin, M.D.

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 If yes, Agent and strength. dosage.	Yes	No

_____

_____

_____