OBSTETRIC QUESTIONNAIRE

Please complete this form to the best of your knowledge to assist us with your prenatal care.

NAME: ____ **AGE:** _______________ **DATE:** ____________

WHEN WAS THE FIRST DAY OF YOUR LAST MENSTRUAL PERIOD: ______________________________________

1. PAST PREGNANCIES

Number: ______________________________ Premature: _______________________________
Full Term: _____________________________ Abortions: _______________________________
Miscarriages: ___________________________ Ectopic (Tubal Pregnancy): __________________

Place an (X) by any of the following problems if it occurred with a previous pregnancy:

______ Premature Labor
______ Still Born
______ Birth Defects
______ High Blood Pressure
______ Kidney Infection
______ Diabetes

2. YOUR PAST MEDICAL HISTORY

Place an (X) by the following if they apply to your medical history:

______ Diabetes
______ Blood Clots
______ Heart Disease
______ Kidney Disease
______ Blood Transfusion
______ Inutero DES Exposure
______ Migraine headaches
______ Hepatitis/Liver Disease
______ High Blood Pressure
______ Thyroid Disease
______ Kidney stones
______ Infertility
______ Anesthetic Complications
______ Physical/Sexual Abuse
______ Asthma
______ Tuberculosis
______ Abnormal Pap
______ Frequent UTI's
______ Seizures
______ Depression

3. INFECTION SCREENING

Place an (X) by the following if they apply to you:

______ Known sexual contact with a person with AIDS or Hepatitis
______ Current or past IV drug usage
______ Current or past sexual partner who is bisexual, hemophiliac, or IV drug user
______ History of gonorrhea, syphilis, chlamydia, or genital warts
______ History of genital herpes

4. GENETICS SCREENING

Place an (X) if this has occurred in your family or the baby's father's family:

______ Mediterranean (Italian, Greek) or Oriental background
______ Neural tube defect (spina bifida, anencephaly)
______ Ashkenazi Jewish (Tay-sachs)
______ Sickle Cell Disease/Trait
______ Huntington's Chorea
______ Birth Defects
______ Downs Syndrome
______ Hemophilia
______ Muscular Dystrophy
______ Cystic Fibrosis
______ Mental Retardation
______ Other Hereditary Diseases

5. PRESENT PREGNANCY

Place an (X) if this has occurred in the current pregnancy:

______ Smoking
______ Alcohol
______ Street Drugs
______ Fever
______ Rash or Viral Illness
______ Prescription Medications
______ Abdominal Pain
______ Vaginal Bleeding/Odor
______ Over-the-counter medications
______ Vomiting

The prenatal lab tests routinely obtained by Northeast OB/GYN Associates include a complete blood count, a blood type and screen, and screening tests for Rubella immunity, Syphilis, Hepatitis, and the Human Immuno-Deficiency Virus (the cause of AIDS).

____ ______________________________
PATIENT'S SIGNATURE DATE

Revised 2/18/09