Name _____ DOB _____

# OBSTETRICS QUESTIONNAIRE

Welcome to Loch Haven Ob/Gyn ! We are pleased that you have chosen us to help care for you during this exciting time. Please fill out this very important questionnaire as completely as possible so that we can help make sure you have a safe and healthy pregnancy.

**Demographic Data:**

Your name: _____ Today's Date: _____

Baby's father's name: _____ Unknown IVF w sperm donation

The best numbers to reach you during the daytime: _____ _____

Do you have a primary care provider? Yes No If yes, whom? _____

Have you been receiving care from another obstetric provider this pregnancy? Y N

(If so, which practice? _____)

**Due Date Determination**:

1st day of your last menstrual period: _____/_____/_____ Are your period regular? Y N
Circle only 1: Exact Unknown Approximate (Closest date): _____

Infertility patients: Is this an in-vitro pregnancy: Yes No. IUI (uterine insemination) : Yes No

Have you had a sonogram during this pregnancy: Yes No
If yes, date: _____ Where? _____

**Allergies**:

Are you allergic to any medications? Y N

| Medications | Allergic Reaction (for example, rash, throat closing) |
|---|---|
| | |
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| | |
| | |
| | |

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**Medical History:** Have you ever had any of these medical conditions?

| CONDITION | Yes | No | CONDITION | Yes | No | CONDITION | Yes | No |
|---|---|---|---|---|---|---|---|---|
| Abnormal uterus | | | Hepatitis | | | Pulmonary embolism | | |
| Anemia | | | Jaundice | | | Pyelonephritis | | |
| Blood transfusion | | | Kidney disease | | | Rheumatic fever | | |
| Chlamydia | | | Liver disease | | | Seizures | | |
| Deep vein thrombosis (DVT) | | | Lupus | | | Stroke | | |
| Depression | | | Migraine headache | | | Syphilis | | |
| Diabetes | | | Mitral valve prolapse | | | Thyroid problems | | |
| Endocrine problems | | | Multiple UTIs | | | Tuberculosis | | |
| Genital Herpes | | | Neurological problems | | | Varicosities | | |
| Gestational Diabetes | | | Pelvic inflammatory disease (PID) | | | Vasculitis | | |
| Gonorrhea | | | | | | Venereal warts | | |
| Heart Disease | | | | | | | | |

I have the following condition(s) not listed: _____.

_____.

**Surgical History:**

| PROCEDURE | Yes | No | PROCEDURE | Yes | No | PROCEDURE | Yes | No |
|---|---|---|---|---|---|---|---|---|
| Cerclage (stitch in cervix to hold the baby in) | | | Cryosurgery (freezing cervix for abnormal Pap) | | | Leep procedure (burning cervix for abnormal Pap) | | |
| Cervical conization (for abnormal Pap) | | | D&C | | | Removal of fibroids | | |
| Cesarean delivery | | | | | | | | |

If you have had fibroids removed, how was this done (circle):

Laparoscope Robot Abdomen (bikini or "up and down" cut) Hysteroscope Unsure

Other surgeries not listed: _____

_____

_____

# OBSTETRICS QUESTIONNAIRE

**Family History:**

I am adopted: Yes No If adopted, I do not know my family medical history: Yes No

| | Birth Defect | Bleeding disorder | Blood clots | Cancer Breast | Cancer Colon | Cancer Uterus | Diabetes | Down Syndrome | Heart Disease | Genetic (other) | Melanoma | Osteoporosis | Stroke | Twins | Allergic rhinitis | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Mother | | | | | | | | | | | | | | | | |
| Father | | | | | | | | | | | | | | | | |
| Sister | | | | | | | | | | | | | | | | |
| Brother | | | | | | | | | | | | | | | | |
| M GRP | | | | | | | | | | | | | | | | |
| P GRP | | | | | | | | | | | | | | | | |
| Child | | | | | | | | | | | | | | | | |
| M RLT | | | | | | | | | | | | | | | | |
| P RLT | | | | | | | | | | | | | | | | |

M = maternal (mother's side). P= paternal (father's side). GRP = grandparent. RLT = relative.

Family Medical History (Continued)

| | Alcohol problems | Allergy (other) | Alzheimers | Asthma | Cancer (lung) | Cancer (other) | Cancer (prostate) | Eczema | Endometriosis | Gallbladder Disease | GI Disease | HIV | Hypertension | Seizure Disorder | Sickle Cell | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Mother | | | | | | | | | | | | | | | | |
| Father | | | | | | | | | | | | | | | | |
| Sister | | | | | | | | | | | | | | | | |
| Brother | | | | | | | | | | | | | | | | |
| M GRP | | | | | | | | | | | | | | | | |
| P GRP | | | | | | | | | | | | | | | | |
| Child | | | | | | | | | | | | | | | | |
| M RLT | | | | | | | | | | | | | | | | |
| P RLT | | | | | | | | | | | | | | | | |

Name _____ DOB _____

# OBSTETRICS QUESTIONNAIRE

**Medications:**

Please list medications and dosages.

| Medication | Dosage | How often? | Which doctor prescribed this? |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |

**Substance and Sexuality:**

Smoking (circle): Never Current Used to but quit (how long ago)? _____
If yes, which type? Cigarettes Cigars Pipe Chew
If yes, number of packs/day: _____
If yes, how many years? _____
Are you ready to quit: Yes No

Alcohol: Yes No
If yes, circle: Liquor Wine Beer
If yes, how many total drinks per week? _____
Have you had any alcohol during this pregnancy? Yes No

Drug use: Do you use illegal drugs? Yes No
If yes, which types (circle)? Marijuana Cocaine Heroin Ecstasy Crystal Meth Amphetamines

Do you use Rx pain medications? Yes No
If yes, which types (circle)? Percocet Roxicet Oxycodone Methadone

Do you use anxiety medications? Yes No
If yes, which types (circle)? Valium Xanax Other

Sexuality: Are you currently sexually active? Yes No
When active, your partner is: Male Female

# OBSTETRICS QUESTIONNAIRE

**Obstetrics history (your prior pregnancies)**:

Please fill out the table with information about every one of your pregnancies. If you do not know the information, please leave it blank.

This is my first pregnancy: Yes No (If yes, skip this section)

| | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| Date (date/month/yr) | | | | | | | | |
| Full term? | | | | | | | | |
| Preterm delivery? (< than 37 weeks) | | | | | | | | |
| How many weeks were you at delivery? | | | | | | | | |
| Miscarriage | | | | | | | | |
| Termination? | | | | | | | | |
| Ectopic? | | | | | | | | |
| Stillbirth? | | | | | | | | |
| Twins, triplets | | | | | | | | |
| Vaginal? | | | | | | | | |
| Vacuum? | | | | | | | | |
| Forceps? | | | | | | | | |
| Cesarean? | | | | | | | | |
| Gender | | | | | | | | |
| Is baby living? | | | | | | | | |
| Baby's Weight(s) | | | | | | | | |
| Baby's name(s) | | | | | | | | |
| Where delivered? | | | | | | | | |
| Low fluid around baby? (oligohydramnios) | | | | | | | | |
| Fetal growth restriction? | | | | | | | | |
| Cerclage (stitch to hold baby in)? | | | | | | | | |

Name _____ DOB _____

# OBSTETRICS QUESTIONNAIRE

OB QUESTIONNAIRE

| # | Question | Yes | No | Comments |
|---|---|---|---|---|
| 1 | (If this is your first pregnancy please skip to question # 11) | | | |
| 2 | Have you had a pregnancy complicated by postpartum hemorrhage? | | | Which pregnancies (dates): |
| 3 | Have you had a blood transfusion after delivery | | | |
| 4 | Have you had a pregnancy complicated by shoulder dystocia (where the baby is stuck after delivery, which requires special maneuvers to deliver)? | | | Which pregnancies: |
| 5 | Have you had a baby born over 9 pounds? | | | Which pregnancies: |
| 6 | Have you had gestational (pregnancy) diabetes? | | | Which pregnancies: |
| 7 | Have you ever required a cerclage (stitch to hold in the baby)? | | | Which pregnancies: |
| 8 | Have you had a pregnancy with preeclampsia or hypertension | | | Which pregnancies: |
| 9 | Have you had 3 or more miscarriages? | | | |
| 10 | Have you ever had a pregnancy where the baby had a GBS (group B strep) infection *after delivery*? | | | Which pregnancies: |
| 11 | Have you been treated for infertility? | | | |
| 12 | Have you ever had anesthetic complications? | | | |
| 13 | Within the last year, has someone hit, slapped, kicked or otherwise hurt you? | | | |
| 14 | Within the last year, has anyone forced you to have sex when you didn't want to? | | | |
| 15 | Have you had excessive bleeding after surgery, delivery, or dental work? | | | |
| 16 | Have you had a major accident or had serious trauma (please describe). | | | Please describe: |
| 17 | Even in a life or death situation, would you refuse a blood transfusion? | | | |
| 18 | Have you or the father of your baby ever had a baby with a birth defect? (Describe). | | | Please describe: |

| | | | | |
|---|---|---|---|---|
| 19 | Are you or the baby's father of Ashkenazi Jewish descent? | | | |
| 20 | Are you or the baby's father of European Jewish descent? | | | |
| 21 | Are you or the baby's father of Southeast Asian descent? | | | |
| 22 | Are you or the baby's father of French Canadian or Cajun descent? | | | |
| 23 | Are you or the baby's father of Mediterranean descent? | | | |
| 24 | Is there a personal or family history of any of the following: cystic fibrosis, Tay Sachs, thalassemia, fragile X, autism, muscular dystrophy, Huntington's chorea, mental retardation, PKU? | | | Please circle and describe which family member had this: |
| 25 | Have you ever had Chickenpox? | | | |
| 26 | Are you vaccinated against Chickenpox? | | | |
| 27 | Have you been exposed to tuberculosis? | | | |
| 28 | Have you been diagnosed with tuberculosis? | | | |
| 29 | Does your sexual partner have genital herpes? | | | |
| 30 | Have you had any other infectious diseases? | | | Please list: |

Name _____ DOB _____

# OBSTETRICS QUESTIONNAIRE

## Depression Screening Questionnaire

| **Name:** | **Date:** | | | |
|---|---|---|---|---|
| **Over the last two weeks, how often have you been bothered by any of the following problems?** | **Not at all** | **Several days** | **More than half the days** | **Nearly every day** |
| Little interest or pleasure in doing things | 0 | 1 | 2 | 3 |
| Feeling down, depressed, or hopeless | 0 | 1 | 2 | 3 |
| Trouble falling or staying asleep, or sleeping too much | 0 | 1 | 2 | 3 |
| Feeling tired or having little energy | 0 | 1 | 2 | 3 |
| Poor appetite or overeating | 0 | 1 | 2 | 3 |
| Feeling bad about yourself, or that you are a failure, or have let yourself or your family down | 0 | 1 | 2 | 3 |
| Trouble concentrating on things, such as reading the newspaper or watching television | 0 | 1 | 2 | 3 |
| Moving or speaking so slowly that other people could have noticed? Or the opposite, being so fidgety or restless that you have been moving around a lot more than usual. | 0 | 1 | 2 | 3 |
| Thoughts that you would be better off dead or of hurting yourself in some way | 0 | 1 | 2 | 3 |
| | ___ | **+** ___ | **+** ___ | **+** ___ |
| **If you checked off any problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?** | Not difficult at all ___ | Somewhat difficult ___ | Very difficult ___ | Extremely difficult ___ |