Oakdale OB/GYN

New OB Patient Questionnaire

Date:___________________________________ Date of Birth: ________________

Patient Name: _______________________________________ Preferred Name:______________________

PREGNANCY HISTORY:

First day of your last menstrual period:	
Are your cycles regular? YES NO How many days in between cycles?	
Date of Pregnancy Test:	
Any spotting or ER visits since you conceived? YES NO Have you had an ultrasound? YES NO	
Will you be 35 years of age or older at your due date? YES NO	
Pre pregnancy weight:	
Is your family complete after this baby? YES NO Uncertain	
What is your post partum birth control plan?	
How much do you exercise? None 1x/week 2-3x/week 4 or more x/week	
In the last 6 months have you traveled to an area affected by Zika, malaria, or TB? YES NO	
How much alcohol did/do you drink:	Pre-pregnancy? Now?
Do you smoke cigarettes? YES NO QUIT	If quit, date of last cigarette? If yes, how many cigarettes per day?
Do you use illegal drugs? YES NO QUIT	If quit, date of last use and drug(s)? If yes, which drug(s) and how much?
Do you drink caffeine? YES NO	If yes, how much and how often?

OB HISTORY: For established Oakdale OB/GYN patients: If you have not had any pregnancies since your last delivery with Oakdale you may skip this section.

Total # of Pregnancies (include this one):____________

# Full Term Births (37wks+)	# Premature Births (<37wks)	# Abortions
#Miscarriages	#Tubal Pregnancies	#Living Children

Birth Date	Weeks Gestation	Baby's Weight	Baby's Sex	Type of Delivery	Location of Delivery	Complications? (ex. Hemorrhage, bad tear)

INFECTION & OCCUPATIONAL HAZARDS HISTORY:

Exposure to lead or chemicals?	YES	NO
Exposure to radiation?	YES	NO
Exposure to infections (hospital, teaching, daycare) ?	YES	NO
Do you have cats?	YES	NO

PERSONAL MEDICAL HISTORY (YOUR HISTORY):

	NO (X)	YES (List details, medications and diagnosis date)
Herpes / Other STD		
Diabetes		
High blood pressure		
Heart disease or defect		
Chicken pox		
Autoimmune disease		
Epilepsy / Seizure disorder		
Kidney disease/ UTI		
Mental Illness / Depression/Anxiety		
Hepatitis / Liver disease		
Blood clots (DVT/PE)		
Thyroid disease		
Trauma / Major Injury		
Domestic violence		
Chronic back pain		
Anemia		
Asthma		
DES exposure		
Infertility		
Eating disorder		
Anesthetic Reactions		
Migraines / Headaches		

SOCIAL HISTORY:

Marital Status:		
Name of spouse or partner:		
Your race:		
Race of the baby's father:		
Your occupation:	Partner's Occupation:	
Do you have family support at home?	YES	NO
Do you have housing concerns?	YES	NO
Do you feel safe at home?	YES	NO
Do you have any cultural or religious needs?	YES	NO

GENETIC HISTORY: For you and the baby's father:

	No	Yes (List relationship)
Diabetes?		
Canavan Disease (Jewish Background)?		
Thalassemia (Italian, Greek, Mediterranean, or Asian background)?		
Recurrent pregnancy loss (3 or more), or stillbirth?		
Tay-Sachs (Jewish, Cajun, French Canadian)?		
Sickle Cell Disease or Trait?		
Cystic Fibrosis?		

Maternal Metabolic Disorder?		
Neural Tube Defect (spina bifida)?		
Heart problems in infancy or childhood?		
Down Syndrome?		
Intellectual Disability? If yes, was the person tested for fragile X?		
Other inherited genetic or chromosomal disorders?		
Hemophilia?		
Muscular Dystrophy?		
Other birth defects not listed?		
PKU?		
DVT/PE (blood clots)?		

HEALTH MAINTENANCE AND SCREENING TESTS & WHEN THEY WERE LAST PERFORMED:

Pap Test Date:				
Any abnormal Pap results? YES NO				
If abnormal Pap result please list the YEAR of abnormal result:				
If abnormal Pap how was it treated?				
Cholesterol	Date:	NORMAL	HIGH	
Diabetes Screening	Date:	NORMAL	HIGH	
Thyroid Screening	Date:	LOW	NORMAL	HIGH
Genetic Carrier Screening	NO	YES	DATE:	RESULT:

CURRENT MEDICATIONS: Include prescription and over the counter medications, including vitamins and herbal medications.

Medication	Dose

ALLERGIES: (food, medications, environmental, etc.)

Allergy	Reaction

PAST SURGERIES:

Surgery	Date