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OB/GYN

Obstetrics Questionnaire

TMC
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Name _____ Date of Birth _____
Name of Father of Baby _____ Marital Status _____

Your age at your due date? _____ years old
Is this pregnancy the result of infertility treatments? ☐ Yes ☐ No Type _____
First day of your last menstrual period _____ Was it normal? ☐ Yes ☐ No
How often do you get your menstrual cycle? Every _____ days, lasting _____ days
Date of first positive pregnancy test _____
Were you on birth control at the time of conception? ☐ Yes ☐ No Type_____
If you've had other pregnancies, is the father of this baby the same as your other children? ☐ Yes ☐ No
What medications have you taken since your last period? _____
Do you have a cat? ☐ Yes ☐ No Who changes the litter box? _____

Your ethnicity

☐ African-American ☐ Caucasian ☐ Jewish
☐ Asian ☐ French-Canadian ☐ Mediterranean
☐ Cajun ☐ Hispanic ☐ Other _____

Father of baby's ethnicity

☐ African-American ☐ Caucasian ☐ Jewish
☐ Asian ☐ French-Canadian ☐ Mediterranean
☐ Cajun ☐ Hispanic ☐ Other _____

For both you & the father of the baby, is there a family or personal history of the following?

	Yes (who/what)	No		Yes (who/what)	No
Thalassemia			Muscular Dystrophy		
Sickle Cell or Trait			Cystic Fibrosis		
Congenital Heart Defect			Huntington Chorea		
Neural Tube Defect			Hemophilia		
Down's Syndrome			Mental Retardation or Autism		
Canavan Disease			Familial Dysautonomia		
Tay-Sachs			Recurrent pregnancy loss or stillbirth		
Prior child with birth defect			Other inherited, genetic or chromosomal disorders		

Details _____
_____

Do you or your sexual partner have a history of the following?

	Yes	No	Immunized?		Yes	No	Immunized?
Hepatitis B or C				Rash or illness since last period			
Tuberculosis or exposure				History of STD			
Genital herpes				Chicken Pox			
HIV/AIDS				Syphilis			

Details _____
_____

Are you interested in screening for birth defects & chromosomal abnormalities? ☐ Yes ☐ No ☐ Maybe
Do you want a blood test to determine if you carry the gene for Cystic Fibrosis (Caucasian & Jewish patients at highest risk) ☐ Yes ☐ No ☐ Maybe

Patient Signature _____ Date _____