OB Patient Health History Questionnaire

Please fill out this health history questionnaire thoroughly and specifically. It is important information which will enable us to spend more time discussing your medical condition.

Name: ____ DOB: ______________ Age: ___________ Date: ____________________

What is your current marital status? Single Married Divorced Widowed Engaged

Reason for today's visit/Problems to discuss with the doctor: ____

What surgeries have you had? Please be as specific as possible.

Month/Year	Surgery	Any Complications?

What medications are you currently taking? Please include vitamins and over-the-counter medications.

____

____

What medications are you allergic to? ____

What medical problems have you had in the past? Please explain specifically.

- ☐ High Blood Pressure
- ☐ Heart Disease
- ☐ Cholesterol Problems
- ☐ Blood Clots
- ☐ Anemia or Blood Disorders
- ☐ History of Blood Transfusions
- ☐ Diabetes
- ☐ Thyroid Disorders
- ☐ Asthma
- ☐ Tuberculosis
- ☐ Lung Disorders
- ☐ Stomach or Bowel Disorders
- ☐ Other problems:
- ☐ Hepatitis or Liver Disorders
- ☐ Kidney Stones
- ☐ Kidney Disease
- ☐ Seizures
- ☐ Migraine Headaches
- ☐ Neurological Disorders
- ☐ Depression or Psychiatric Disorders
- ☐ Cancer
- ☐ Birth Defects
- ☐ Anesthesia Complications
- ☐ Infertility
- ☐ Abnormal Pap Smear

Gynecological History

When was your last Pap Smear? __________ Was it normal? Yes No

Have you ever had any abnormal pap smears or precancerous results? Yes No

Do you still have periods? __________ If not, at what age did they stop? __________ Why? Menopause Surgery Other

When was the first day of your last period? __________ Was it normal? Yes No

How old were you when you began having periods? __________ How often do you have periods? __________

How long do they last? __________ Are they painful? Yes No How many days are painful? ___________

Do you have problems with your bladder? Leakage Urgency Frequency Burning

Do you check your breasts for lumps? Yes No How often? ________ Have you found any? Yes No

Name: ____ DOB: _______________

Are you sexually active? Yes No If not, have you ever been sexually active? Yes No

Are you sexually active with..(Circle one) Men Women Both

Have you had multiple sexual partners in the recent past? Yes No

Have you been exposed to or had sexually transmitted diseases? Yes No Have you had Herpes or HSV? Yes No

Social History

Do you exercise regularly? Yes No How many times per week? ______________

(At least 30 minutes of physical activity; Ex. walking, jogging, weights, swimming, cycling)

Describe your diet: (Check one)

______ I eat whatever I want without regard to calories or health content

______ I try to eat a balanced diet with fruits, vegetables, and proteins, and limit my sugar intake and fried foods

______ I eat very healthy and avoid sugars, fried, and fast foods

______ Other, please describe. ____

Do you smoke? Yes No If yes, how much per day? ___________ How long have you smoked? ___________

If a non-smoker, have you smoked in the past? Yes No

Childbirth History

How many times have you been pregnant? ______ How many children are still living? ______

How many were born full term? (more than 37 weeks) ______ How many were early? (less than 37 weeks) ______

How many abortions? ______ How many miscarriages? ______ How many tubal pregnancies? ______

Please explain each pregnancy, including pregnancy losses. List specific complications like: Pre-term labor, Still Born, Birth Defects of baby, High Blood Pressure, Diabetes, Other.

No	Date of Birth	How many weeks pregnant?	Weight	Sex	Vaginal or C-Section?	Epidural?	Complications?	Location
1								
2								
3								
4								
5								
6								
7								

Name: ______________________________________ DOB: ______________

Other

Have you had chicken pox? Yes No If not, have you had Varicella Vaccination? Yes No

Do you have any religious or ethical objection to receiving blood products? Yes No

Do you currently feel safe at home? Yes No

Do you have close contact with children on a regular basis? Yes No

Have you or your partner traveled outside the U.S. in the last 6 months? Yes No If yes, where? ______________________

Have any of these occurred in your family or your baby's father's family?

- ☐ Mediterranean (Italian, Greek) or Oriental background What relation? ________________________
- ☐ Neural Tube Defect (Spina Bifida, Anencephaly) What relation? ________________________
- ☐ Tay-Sachs (Jewish, French Canadian) What relation? ________________________
- ☐ Sickle Cell Disease/Trait What relation? ________________________
- ☐ Huntington's Chorea What relation? ________________________
- ☐ Birth Defects What relation? ________________________
- ☐ Down Syndrome What relation? ________________________
- ☐ Hemophilia/Blood Disorders What relation? ________________________
- ☐ Muscular Dystrophy What relation? ________________________
- ☐ Cystic Fibrosis What relation? ________________________
- ☐ Mental Retardation/Autism What relation? ________________________
- ☐ Congenital Heart Defect What relation? ________________________
- ☐ Canavan's Disease What relation? ________________________
- ☐ Other hereditary diseases/chromosomal disorders What relation? ________________________

Name: ____ DOB: ______________

Do you drink alcohol? Yes No If yes, please answer the following questions:

Have you ever felt you ought to cut down on your drinking? Yes No

Have people annoyed you by criticizing your drinking? Yes No

Have you ever felt bad or guilty about your drinking? Yes No

Have you ever had a drink first thing in the morning to steady your nerves or get rid of a hangover? Yes No

SCORE ____________

Have you ever experimented with recreational or prescription drugs? Yes No If yes, please answer the following questions:

Have you ever felt you ought to cut down on your drug use? Yes No

Have people annoyed you by criticizing your drug use? Yes No

Have you ever felt bad or guilty about your drug use? Yes No

Have you ever used drugs first thing in the morning to steady your nerves? Yes No

SCORE _____________

Depression Screening

Over the last *2 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**
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down depressed or hopeless	0	1	2	3
3. Trouble falling or staying asleep, or sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself or that you are a failure or have let yourself or your family down	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed. Or being so figety or restless that you have been moving around a lot more than usual	0	1	2	3
9. Thoughts that you would be better off dead, or of hurting yourself	0	1	2	3

Add columns ________ + ________ + _______

TOTAL ____________