Hays Women's Health

OB Questionnaire

Although some of the information requested below may not seem pertinent, it helps us provide you with the best care. We ask that you fill out ***ALL of the following questions completely.***

Date: _____ Name: _____

Address: _____

Phone # (Home/Cell): _____ DOB: _____Age: _____

Name of Father of the Baby (FOB): _____

Your Occupation: _____ FOB's Occupation: _____

Preferred Pharmacy: _____

Please list any medications that you are currently taking (include herbal and over the counter): _____

_____

Please list any Significant allergies (medications, latex, eggs, shellfish, etc.): _____

_____

How many times have you been pregnant? _____

When was the first day of your last menstrual period? _____

When was your first pregnancy test positive? _____Was the test ❑ urine? ❑ Blood?

What was your weight at the onset of this pregnancy? _____

How old were you when you had your first period? _____

Are your periods ❑ regular? ❑ irregular?

How often do your periods occur? _____ How many days do you have bleeding? _____

How much did you weigh when you were born? _____ How much did the FOB weigh at birth? _____

Do you have any family history of traumatic births in either of your families? ❑ yes ❑ No

Previous Pregnancies:

Date M/D/Y	Gesta-tional Age (weeks)	Length of Labor (hours)	Birth weight (pounds)	Gender (or N/A)	Delivery Type (vaginal, vacuum, C-Section, miscar-riage)	Anesthesia (none, IV, epidural)	Place of delivery	Complications
5/1/2009	*38.5*	*6.5*	*7.3*	*female*	*C-Section*	*None*	*UTMB Galveston, Tx.*	*Prolonged Labor*

Name: _____ DOB: _____

Medical History: Please list if you have or have not had any of the following:

History	Y/N	Date	Comment	History	Y/N	Date	Comments
Sample: Chicken Pox	*Y*	*Feb-83*	*X*	Infertility			
Sample: Headache	*Y*	*Current*		Liver Disease			
Allergic Rhinitis				Neurologic Disorder			
Anemia/Hematologic				Renal Disease			
Asthma/Pulmonary				(Rh) Sensitized			
Autoimmune Disorder				Thyroid Disorder			
Abnormal Pap Smears				Trauma History			
Breast Disorder				Uterine Abnormalities			
Depression				Varicosities/DVT			
Psychiatric Disorder				Anesthetic Complications			
Diabetes				Other Family History			
Heart Disease							
Hypertension							

Please explain any comments or list other significant medical history: _____

_____

_____

Please list any surgeries or hospitalizations (include year): _____

_____

Did you use tobacco prior to pregnancy? ❑ Yes ❑ No

If so, how many times per (choose one): day _____ /week _____ /month_____?

For how many years? _____

Did you use alcohol prior to pregnancy? ❑ Yes ❑ No

If so, how many times per (choose one): day _____ /week _____ /month_____?

For how many years? _____

Did you or do you now use any illicit recreational drugs (marijuana, cocaine, ecstasy, etc.)? ❑ Yes ❑ No

Did you or your partner have a history of HIV? ❑ Yes ❑ No

Did you or your partner have a history of herpes? ❑ Yes ❑ No

Did you or your partner have a history of any sexually transmitted disease? ❑ Yes ❑ No

If yes, which? _____

Have you been or are you at risk for exposure to tuberculosis? ❑ Yes ❑ No

Have you had a rash or viral illness since your last menstrual period? ❑ Yes ❑ No

Have you had or been vaccinated for chicken pox? ❑ Yes ❑ No

Do you have contact with cats? ❑ Yes ❑ No

Do you eat raw meat or fish? ❑ Yes ❑ No