NORTHWEST WOMEN'S HEALTHCARE

New OB Questionnaire

Name: _____ Preferred Name: _____

Age: _____ Birth Date: _____ Partner's Name: _____

Preferred Pronouns: _____ Pharmacy: _____

Occupation: _____ PCP: _____

Race/Ethnicity: _____ Date of Appt: _____ Referred By: _____

Last menstrual period: _____ Vital Signs: BP _____ P _____

Estimated Due Date (if known): _____ HT _____ WT _____

FERTILITY HISTORY

Have you had infertility treatment? ☐ yes ☐ no If yes, where? _____

If yes, which: ☐ IUI

☐ IVF ◯ Donor Eggs (age of donor: _____) ◯ PGT

OBSTETRICAL HISTORY

#	DATE	PREGNANCY OUTCOME (MISCARRIAGE, VAG DEL, C/S)	LENGTH (WKS)	EPIDURAL?	FETAL SEX	WEIGHT	HOSPITAL	COMPLICATIONS?
1								
2								
3								
4								
5								

GYNECOLOGIC HISTORY

Age at first period? _____

How many days do you bleed? _____

Length of cycles (days between periods)? _____

Any vaginal itching or abnormal discharge? ☐ yes ☐ no

Any history of recurrent ☐ Bacterial vaginosis ☐ Yeast

FOR DOCTORS USE ONLY

HEALTH CARE MAINTENANCE

Date of last pap smear ___/___/_____

Result? ☐ Normal ☐ Abnormal

If abnormal, please list treatment/date _____

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HEALTH CARE MAINTENANCE (CONTINUED)

Have you ever had (mark if yes):

☐ Colposcopy ☐ Cryotherapy ☐ LEEP ☐ Laser

Mammogram? ☐ yes ☐ no If yes, when ___/___/_____

Colonoscopy? ☐ yes ☐ no If yes, when ___/___/_____

Have you ever had an STD? ☐ yes ☐ no

If yes: ☐ Herpes (oral/genital) ☐ Gonorrhea ☐ HPV

☐ Chlamydia ☐ Syphilis ☐ HIV

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SURGICAL HISTORY

Year	Surgical Procedure

MEDICAL HISTORY

YES	NO	HAVE YOU EVER HAD:
☐	☐	Chickenpox or chickenpox (Varicella) vaccine
☐	☐	Depression
☐	☐	Anxiety
☐	☐	Eating disorder
☐	☐	Migraine headaches with aura
☐	☐	Thyroid disorder
☐	☐	High blood pressure
☐	☐	High cholesterol
☐	☐	Heart disease
☐	☐	Echocardiogram
☐	☐	Breast lump evaluated?
☐	☐	Asthma
☐	☐	Deep Vein Thrombosis (DVT)
☐	☐	Pulmonary Embolism (PE)
☐	☐	Stomach ulcers
☐	☐	Intestinal problems
☐	☐	Gallstones
☐	☐	Diabetes
☐	☐	Kidney problems
☐	☐	Liver problems/hepatitis
☐	☐	Blood transfusion
☐	☐	Cancer
☐	☐	Autoimmune disorder
☐	☐	Osteoporosis

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Other Medical History: _____

FAMILY HISTORY

HAVE ANY RELATIVES HAD:	YES	NO	IF YES, WHO?
Breast cancer	☐	☐	
Ovarian cancer	☐	☐	
Colon cancer	☐	☐	
Heart attack	☐	☐	
Stroke	☐	☐	
High blood pressure	☐	☐	
Diabetes	☐	☐	
Birth defects	☐	☐	
Blood clots	☐	☐	
Genetic disorders	☐	☐	
Twins	☐	☐	
Depression/Psychiatric disorders	☐	☐	
Thyroid disorder	☐	☐	

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Other conditions: _____

SOCIAL HISTORY

Are you: ☐ Single ☐ In a relationship ☐ Married ☐ Partnered ☐ Divorced ☐ Other

YES	NO	DO YOU:
☐	☐	Smoke tobacco products?
☐	☐	Drink alcohol (prior to pregnancy)?
☐	☐	Use Marijuana?
☐	☐	Use other recreational drugs?
☐	☐	Suffer ongoing abuse or trauma?
☐	☐	Feel safe?
☐	☐	Wear your seatbelt?
☐	☐	Exercise regularly?
☐	☐	Have guns in the home?
☐	☐	If so, are they secured?
Religious preference:		

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REVIEW OF SYSTEMS

Do you currently have any of the following symptoms?

- ☐ Fever
- ☐ Fatigue
- ☐ Night sweats
- ☐ Headaches
- ☐ Breast lumps
- ☐ Breast tenderness
- ☐ Nipple discharge
- ☐ Chest pain
- ☐ Irregular heart beat
- ☐ Shortness of breath
- ☐ Indigestion/Heartburn
- ☐ Nausea
- ☐ Vomiting
- ☐ Diarrhea
- ☐ Constipation
- ☐ Urinary frequency
- ☐ Discomfort with urination
- ☐ Pelvic pain
- ☐ Cramping
- ☐ Unusual vaginal discharge
- ☐ Rash
- ☐ Joint pain
- ☐ Heat/cold intolerance
- ☐ Depression
- ☐ Anxiety
- ☐ Easy bleeding/bruising
- ☐ Seasonal allergies

MEDICATIONS

Please list current medications, doses, instructions (include vitamins and supplements)

MEDICATION	DOSE	FREQUENCY

Medication allergies (and reaction)

Do you have a latex allergy? ☐ yes ☐ no

VACCINE HISTORY

☐ COVID ☐ Up to date COVID booster(s) ☐ Flu Vaccine ☐ HPV

ANYTHING ELSE WE SHOULD KNOW TO HELP US IN YOUR CARE?