Northwest Women's Healthcare

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NEW OB QUESTIONNAIRE

NAME: _____ PREFERRED NAME: _____

AGE: _____ DATE: _____

RACE/ETHNICITY: _____ PARTNER'S NAME: _____

BIRTHDATE: _____

PRONOUN: ◯ SHE/HER ◯ HE/HIM ◯ THEY/THEM

OCCUPATION _____ REFERRED BY _____

Last Menstrual Period _____ VITAL SIGNS BP _____

HT _____

EDD (Due Date) If known _____ WT _____

HAVE YOU HAD INFERTILITY TREATMENT? ◯ YES ◯ NO

WHERE? _____

SELECT ALL THAT APPLY: ☐ IUI ☐ IVF ☐ Donor Egg ☐ TWINS

OBSTETRICAL HISTORY

#	*Date*	*Pregnancy Outcome (miscarriage, vag del, C/S)*	*Length (wks)*	*Epidural?*	*Gender*	*Weight*	*Name*	*Hospital/DR*
1.								
2.								
3.								
4.								
5.								

HEALTH CARE MATINENCE

The HPV vaccine?			(for doctors use only)
A mammogram?			
A colonoscopy?			
Have you ever had an STD?			
Date of last pap smear			
Have you ever had an abnormal pap?			
Have you ever had a colposcopy, biopsy, laser treatment or LEEP?	*Please select all that apply:*	Biopsy Colposcopy Laser treatment LEEP	
Have you ever had HPV?			

SURGICAL HISTORY

Year | Surgical Procedure | *for doctors use only*

MEDICAL HISTORY

- ☐ Eating disorder
- ☐ Migraine headaches
- ☐ Thyroid disease
- ☐ High Blood Pressure
- ☐ Heart disease
- ☐ Bacterial Vaginosis
- ☐ Breast lump
- ☐ Asthma
- ☐ Deep Vein Thrombosis (DVT)
- ☐ Pulmonary Embolism (PE)
- ☐ Stomach Ulcers
- ☐ Intestinal Problems
- ☐ Gallstones
- ☐ Diabetes - type I or II
- ☐ Kidney Problems
- ☐ Liverproblems/Hepatitis
- ☐ Blood transfusion
- ☐ Cancer
- ☐ Autoimmune Disorder
- ☐ Chicken Pox
- ☐ Anxiety
- ☐ Depression
- ☐ Yeast Infection
- ☐ Urinary Tract Infection

for doctors use only

VACCINES ☐ FLU ☐ COVID-19 ☐ COVID-19 BOOSTER OTHER:

FAMILY MEDICAL HISTORY

Have any relatives had: (who?)	*YES ?*	*WHO?*	*for doctors use only*
Breast cancer	☐	Select	
Ovarian cancer	☐	Select	
Colon cancer	☐	Select	
Heart attack	☐	Select	
Stroke	☐	Select	
High blood pressure	☐	Select	
Diabetes	☐	Select	
Birth defects	☐	Select	
Blood clots	☐	Select	
Genetic disorders	☐	Select	
Twins	☐	Select	
Depression/Psychiatric disorders	☐	Select	
Thyroid disorder	☐	Select	

Other conditions _____

SOCIAL HISTORY

Are you (circle): ◯ Single ◯ In a relationship ◯ Married ◯ Partnered ◯ Divorced ◯ Other

Do you			*for doctors use only*
Smoke tobacco products	◯ yes	◯ no	
Drink alcohol (prior to preg.)	◯ yes	◯ no	
Use Marijuana or other recreational drugs	◯ yes	◯ no	
Wear your seatbelt	◯ yes	◯ no	
Suffer ongoing abuse	◯ yes	◯ no	
Feel safe	◯ yes	◯ no	
Exercise regularly	◯ yes	◯ no	
Have guns in the home	◯ yes	◯ no	

Religious Preference: _____

REVIEW OF SYSTEMS

- ☐ Cramping
- ☐ Night sweats
- ☐ Indigestion/Heartburn
- ☐ Unusual vaginal discharge
- ☐ Fatigue
- ☐ Nausea
- ☐ Rash
- ☐ Headaches
- ☐ Vomiting
- ☐ Joint pain
- ☐ Diarrhea
- ☐ Breast lumps
- ☐ Breast tenderness
- ☐ Constipation
- ☐ Easy bleeding/Bruising
- ☐ Nipple Discharge
- ☐ Urinary Frequency
- ☐ Seasonal Allergies
- ☐ Chest pain
- ☐ Discomfort with urination
- ☐ Anxiety
- ☐ Irregular heartbeat
- ☐ Pelvic pain
- ☐ Depression

MEDICATIONS

MEDICATIONS

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

Medication	Dose	Frequency

MEDICATION ALLERGIES (and reaction)

Do you have a Latex allergy? Please Select: ◯ yes ◯ no

Seasonal Allergies?

Food Allergies?

Anything else we should know to help us in your care?