Northwest Women's Healthcare

NEW OB QUESTIONNAIRE

NAME _____ DATE _____

AGE _____ PARTNER'S NAME _____

BIRTHDATE _____ PCP _____

PREFERED PRONOUN SHE/HER HE/HIM THEY/THEM

OCCUPATION _____ REFERRED BY _____

Last Menstrual Period _____ VITAL SIGNS BP _____ P _____

EDD (Due Date) If known _____ HT _____

WT _____

HAVE YOU HAD INFERTILITY TREATMENT? YES NO

WHERE? _____

CIRCLE 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	Complications
1									
2									
3									
4									
5									

GYNECOLOGIC HISTORY

for doctors use only

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 (circle) Bacterial vaginosis Yeast

HEALTH CARE MAINTENANCE

for doctors use only

Date of last pap smear _____

Was it (please circle) Normal Abnormal

If Abnormal, please list treatment/date _____

Have you ever had:

An abnormal pap? If yes, when _____ yes no

Colposcopy/Cryotherapy/Biopsy/Laser/LEEP (circle)

Human Papillomavirus (HPV) yes no

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HEALTH CARE MAINTENANCE (continued)

The HPV vaccine	yes	no
A mammogram (date) _____	yes	no
A colonoscopy (date) _____	yes	no
Have you ever had an STD?	yes	no

If yes, circle: Herpes (oral/genital) Gonorrhea Chlamydia Syphilis HIV

SURGICAL HISTORY

Year	Surgical Procedure	*for doctors use only*

MEDICAL HISTORY

Have you ever had:	*yes*	*no*	*for doctors use only*
Depression/Anxiety			
Eating disorder			
Migraine headaches			
Thyroid disease			
High Blood Pressure			
Heart disease			
Echocardiogram			
Breast lump			
Asthma			
Deep Vein Thrombosis (DVT)			
Pulmonary Embolism (PE)			
Stomach ulcers			
Intestinal problems			
Gallstones			
Diabetes			
Kidney problems			
Liver problems/Hepatitis			
Blood transfusion			
Cancer			
Autoimmune Disorder			
Chicken Pox			

Other Medical History: _____

FAMILY HISTORY

Have any relatives had: (who?)	*yes*	*no*	
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			

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 take other recreational drugs	yes	no	
Wear your seatbelt	yes	no	
Suffer ongoing abuse	yes	no	
Feel safe	yes	no	
Exercise regularly	yes	no	
Religious preference _____			
Have guns in the home	yes	no	
If so, are they secured	yes	no	

REVIEW OF SYSTEMS

Do you currently have any of the following symptoms (please circle)

Fever	Shortness of breath	Cramping
Night sweats	Indigestion/Heartburn	Unusual vaginal discharge
Fatigue	Nausea	Rash
Headaches	Vomiting	Joint Pain
Breast Lumps	Diarrhea	Heat/Cold intolerance
Breast Tenderness	Constipation	Easy bleeding/bruising
Nipple Discharge	Urinary Frequency	Seasonal Allergies
Chest pain	Discomfort with urination	Anxiety
Irregular heartbeat	Pelvic pain	Depression

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 circle: yes no

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