Downers Grove OB/GYN
Obstetrics Questionnaire

Patient Name: _____ Date of Birth: _____

Marital Status (check one): Married _____ Single _____ Divorced _____

Spouse's Name: _____

Preferred Local Pharmacy: _____

OB History

How many times have you been pregnant? _____ Spontaneous miscarriages? _____

How many full term deliveries? _____ Any terminations? _____

Premature? _____ Living Children? _____

Stillbirths? _____

Year	Vaginal/Cesarean	Sex	Weight	Complications?	Name

Menstrual and Gynecological History:

First date of last period: _____

Are your periods regular? Yes _____ No _____

Cycle length (how many days?) _____

How many days from the first day of your periods to your next period: _____

Is your flow: Light _____ Moderate _____ Heavy _____

When was your last pap smear: _____

Have you ever had an abnormal pap smear: Yes _____ No _____

Medical History

Please indicate any significant family history that applies to you with a check mark placed below:

	You	Family		You	Family
Alcoholism			Heart disease		
Anemia (low iron)			Hepatitis		
Autism			Hypertension		
Asthma			Infertility		
Bleeding/clotting disorder			Kidney disease		
Cancer			Liver disease		
Chromosomal anomaly			Lung disease		
Congenital anomaly			Psychiatric disorder		
Depression			Sexually transmitted disease		
Diabetes			Thyroid disease		
Gastrointestinal disorder			Domestic violence		
Exposure to cat feces			Other		

Past Surgical History

List significant surgeries below: None: _____

Year	Surgery

Medications

List any prescription medications, vitamins, minerals, and herbs that you are currently taking?

Name of Medication	Dosage

Allergy History

List known allergies (including medication allergies) or check one of the following below:

No known Allergies: _____ No known Drug Allergies: _____

Drug	Reaction

Social History

Please describe your current tobacco use:

Never Smoker _____ Former Smoker _____ Current Every Day _____ Current Some Day Smoker _____

Please describe your current exercise routine:

Inactive _____ Light _____ Moderate _____ Vigorous _____

Ever used any illicit drugs? Yes _____ No _____

Do you drink beverages with alcohol? Yes _____ No _____

Genetic Screen

Check 'yes' if anyone in your family or your spouses family have had the following. Check 'no' if not applicable

Screening	Yes	No	Screening	Yes	No
Will you be 35 years or older at the time of deliery?			Muscular dystrophy		
Thalassemia			Cystic Fibrosis		
Neural tube defect/spina bifida			Huntington's Chorea		
Congenital heart defect			Autism		
Down's Syndrome			If yes to autism, was person tested for fragile X?		
Tay-Sachs disease			Intellectual disability		
Familial dysautonomia			If yes to intellectual disability, was person tested for Fragile X?		
Canavan syndrome (Ashkenazi Jewish)			Recurrent pregnancy loss/stillbirth		
Sickle cell disease/trait			Other inherited genetic/chromosomal disorder		
Hemophilia/hematological disease			Other birth defect		