Medford WOMEN'S CLINIC LLP
obstetrics and gynecology

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OBSTETRICAL QUESTIONNAIRE

GENERAL INFORMATION

Legal name: ____ Date: ____________
Preferred name: ____________________________ DOB: ____________ Age: ____________
Primary phone number: _____________________ Work/other number: _________________
Home address (city/state/zip): ____
Occupation: __________________________ Education (last level): ___________ Religion: _________
Relationship status: ❏ Single ❏ Married ❏ Divorced ❏ Widowed ❏ Other: _______________________
Emergency contact (name/relationship/number): ____
Primary care provider: ______________________ Referred by: _______________________________
Pharmacy preference: ______________________

GYN HISTORY

First date of last menstrual cycle: ____________ Certain: ❏ Yes ❏ No ❏ Unknown
Number of days between cycles: _____________ Cycles regular: ❏ Yes ❏ No ________
Contraceptive methods used in past: ❏ Pills ❏ IUD ❏ Nexplanon ❏ Depo ❏ Patch ❏ Natural family planning ❏ Condoms ❏ Sterilization
Date (& location) of last pap smear: _________________________ ❏ Normal ❏ Abnormal: _____________
History of abnormal paps: ❏ No ❏ Yes: _____________________ Prior LEEP: ❏ No ❏ Yes: ____________
Prior infections: ❏ Chlamydia ❏ Gonorrhea ❏ Genital herpes ❏ Trichomonas ❏ Syphilis ❏ HIV
History of: ❏ Infertility ❏ PCOS ❏ Endometriosis ❏ Pelvic inflammatory disease ❏ Recurrent preg loss

OB HISTORY

Planned pregnancy: ❏ Yes ❏ No Contraception use at conception: ❏ No ❏ Yes: ______________
Partners name: ___________________________ Partner supportive of pregnancy: ❏ Yes ❏ No
Partners first baby: ❏ Yes ❏ No Do they plan to be present at birth: ❏ Yes ❏ No
Partner occupation: ________________________ Partner with genital herpes: ❏ Yes ❏ No
Ultrasounds so far this pregnancy: ❏ Yes ❏ No Pre-pregnancy weight: ________________
Complications this pregnancy: ❏ Severe nausea/vomiting ❏ Weight loss _______________________ ❏ Vaginal bleeding ❏ ER visits __________________________
Are you interested in screening tests for genetic or chromosomal problems: ❏ Yes ❏ No ❏ Uncertain
Have you had carrier screening in the past (ie cystic fibrosis)? ❏ Yes ❏ No ❏ Uncertain
Pediatrician: _____________________ Feeding preference: ❏ Breastfeed ❏ Formula ❏ Other

Pregnancy history (# of): *Full-term:* ___ *Preterm:* ___ *Ectopics:* ___ *Miscarriages:* ___ *Terminations:* ____

Date	Weeks	Birth weight	Sex (*Name*)	Delivery type *(vaginal, forceps, vacuum, cesarean)*	Epidural *(yes/no)*	Complications *(preterm labor, diabetes, high blood pressure, pre-eclampsia, etc)*

Anything from your prior pregnancy, labor or delivery experiences, that you would or would not like repeated:

____

____

____

Anything else you feel your doctor should know about you, your partner, or your family?

____

MEDICAL & SURGICAL HISTORY

MEDICAL CONDITIONS:

- ❏ Diabetes (type 1 or 2)
  - ❏ *Gestational diabetes*
- ❏ High blood pressure
  - ❏ *Pre-eclampsia*
- ❏ Heart disease
- ❏ Blood clotting disorder (DVT, PE)
- ❏ Bleeding disorder (ie Von Willebrands)
- ❏ Blood transfusion
- ❏ Anemia
- ❏ Anesthetic complications
- ❏ Asthma
- ❏ Lung disease
- ❏ Thyroid disease
- ❏ Kidney disease
- ❏ Kidney stones
- ❏ Gastro disease (IBS, celiac, Crohn's, ulcerative colitis)
- ❏ Gallstones
- ❏ Hepatitis
- ❏ Acid reflux
- ❏ Migraines *(aura? – Y/N)*
- ❏ Anxiety
- ❏ Depression
  - ❏ *Postpartum depression*
- ❏ Cancer
- ❏ Seizure disorder
- ❏ Tuberculosis
- ❏ Arthritis or lupus
- ❏ Stroke
- ❏ Other: ______________________
- ❏ Hospitalizations or major illnesses: ____

____

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SURGERIES:

- ❏ Cesarean section
- ❏ Laparoscopy
- ❏ Breast surgery
- ❏ D&C
- ❏ Appendectomy
- ❏ ____
- ❏ Hysteroscopy
- ❏ Cholecystectomy

MEDICATIONS (including over-the counter supplements and vitamins): ________________________________
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____
____

Drug allergies/reaction: ____

Latex allergy: ❑ Yes ❑ No Shellfish allergy: ❑ Yes ❑ No

Accepting of blood transfusion in emergency: ❑ Yes ❑ No ❑ Jehovah's witness

VACCINE HISTORY: Last flu vaccine ______________________ Last Covid vaccine ____________
Gardasil(HPV) vaccine _________________ Last tetanus vaccine __________

SOCIAL HISTORY

❑ Current nicotine – vape/cig (amount/day) ___________ ❑ Former smoker (date last use) _____________
❑ Current alcohol use ____________________ ❑ Prior alcohol use (avg drinks/week) _______________
❑ Current marijuana use (frequency) __________
❑ Recreational drug use (cocaine, opioid, methamphetamine, other): ________________________________
Date of last use _______________ History IV drug use: ❑ Yes ❑ No

Seat belt use: ❑ Regular ❑ Inconsistent ❑ None

Exercise (type/frequency): ____
Hobbies: ____
Do you feel safe at home: ❑ Yes ❑ No ____

FAMILY HISTORY

❑ Tay-Sachs
❑ Canavan disease
❑ PKU
❑ Neural tube defect
❑ Sickle cell
❑ Hemophilia
❑ Thalassemia
❑ Cystic fibrosis
❑ Spinal muscular atrophy
❑ Congenital heart disease
❑ Fragile X
❑ Autism

❑ Down syndrome
❑ Twins

Ancestry:
❑ *Black/African American*
❑ *French Canadian*
❑ *Mediterranean/Southeast Asia*
❑ *Ashkenazi Jewish*

❑ Blood clotting disorder
❑ Diabetes
❑ High blood pressure
❑ Breast cancer
❑ Ovarian cancer
❑ Colon cancer
❑ Anesthetic complication
❑ Recurrent pregnancy loss

❑ Other structural birth defects: ______________________________
❑ Other genetic disorders: ___________________________________

Please elaborate on positive answers: ____
____

12/15/23