Cedar Rapids OB-GYN Specialists, P.C.

OB Patient Questionnaire

Name____**DOB**__________________

Today's Date____________________

Will you be 35 years or older when the baby is due? Yes No

Your occupation_______________________________________

Hospital preference Mercy St. Lukes **Pharmacy preference**________________________

Pediatrician/Family physician that will care for your baby once it's born? _________________

Do you have any religious beliefs that would affect your care? Yes No **If yes, please explain**____

Marital status Single Dating Married Divorced

Name of significant other__________________**Significant other's occupation**______________

Is the father of your baby 55 years old or older? Yes No

Is the father of your baby a blood relative? Yes No

Do you feel safe in your home environment? Yes No

List all medications/dose/frequency and prescribing doctor:

____

____

____

List diagnosed allergies and your reaction:

____

____

Please list any surgeries or hospitalizations that you were admitted for:

Year	Description	Year	Description

Do you have or have you ever had history of the following:

Abnormal Pap Tests	Yes	No	High Blood Pressure	Yes	No
Arthritis	Yes	No	Heart Disease	Yes	No
Asthma	Yes	No	Kidney/Bladder problems	Yes	No
Blood Clots	Yes	No	Malignant Hyperthermia	Yes	No
Blood Transfusion	Yes	No	Mitral Valve Prolapse	Yes	No
Bowel Disorders	Yes	No	Phlebitis	Yes	No
Chicken Pox	Yes	No	PCOS	Yes	No
Chlamydia	Yes	No	Pre-Eclampsia	Yes	No
Depression	Yes	No	PUPPS	Yes	No
Diabetes ___ type 1 ___ type 2	Yes	No	Severe Headaches	Yes	No
Gestational Diabetes	Yes	No	Stomach Problems	Yes	No
Gonorrhea	Yes	No	Thyroid Disease	Yes	No
Hepatitis	Yes	No	Trichomonas	Yes	No
Herpes	Yes	No	Urinary Incontinence	Yes	No
HPV	Yes	No	Yeast Infection	Yes	No

Other: ____

Have any of *your* close relatives had any of the following conditions?

Condition	Relationship to you Maternal (mom's side) Paternal (dad's side)	Age at Onset
Breast Cancer		
Colon Cancer		
Diabetes Type 1 or Type 2		
Heart Attack		
High Blood Pressure		
Ovarian Cancer		
Stroke		
Thyroid Disorder/Cancer		
Multiple Births		
Other		

Date of last pap smear__________ Results: Normal Abnormal

History of abnormal pap smear? Yes No

If yes what procedures have you had performed_______________________________________

How old were you when you started having periods? __________

First day of last period________How many days between periods (first day to first day) _____

How many days do your period last? _____

Do you have any tattoos? Yes No

Body piercing/where (other than ears)? ____

Smoking/Tobacco products? Yes No **# of cigarettes per day_____**

Have you drunk alcohol during the pregnancy? Yes No **How many wks were you then_____ How much have you drank? ____**

Have you used any recreational drugs during the pregnancy or in the past? Yes No

If yes, what did you use and how many weeks were you ______________________________

Has the father of your baby used any recreational drugs during your pregnancy or in the past? Yes No **if yes, what did he use____**

Caffeine Use Yes No **What and how much per day_______________________________**

Do you have cats? Yes No Indoor Outdoor or Indoor and Outdoor

Have you had a fever over 101 degrees during this pregnancy? Yes No

Have you used a whirlpool/sauna since becoming pregnant? Yes No

Have you had an x-ray or surgery since becoming pregnant? Yes No

Do you exercise (activity outside of your normal daily routine)? Yes No **List activity, and how many time in a wk do you do the activity____**

____

Do you wear your seatbelt? Always Sometimes Never

Do you plan to breast feed? Yes No

Pregnancy History

Total pregnancies _____Ectopic pregnancies _____Premature birth 36 weeks or earlier_____

Abortions_____ Miscarriages_____ Multiples_____ Living children_____

Have you or the baby's father, or the spouse of the baby's father in a previous marriage had three or more spontaneous pregnancy losses? Yes No

Please list all pregnancies in chronological order

Delivery Date	Weeks of pregnancy	Length of Labor	Birth Wt.	Sex	Type of Delivery Vaginal/Forceps Vacuum/C/S	Name of Child	Complications

What is your race? White Black Asian American Indian/Alaskan Native

Native Hawaiian/Pacific Islander Unknown

Other______________________

What is your Ethnicity? Hispanic Non Hispanic Unknown_________________

What is your heritage? ____

What is the father of the baby's heritage? ____

Do you or the father of your baby have any close relative descended from Jewish people who lived in Eastern Europe (Ashkenazic Jew)? Yes No

If yes, have either of you been screened for Tay-Sachs disease? Yes No

If you or the father of your baby are of Italian, Greek or Mediterranean background, have either of you been tested for B-thalassemia? Yes No

If you or the father of your baby are of Philippine or South East Asian decent, have either of you been tested for Alpha-thalassemia? Yes No

If you or the father of your baby are black, have either of you or a close relative been screened for Sickle Cell trait? Yes No

Please circle "Yes" or "No" if you or the father of your baby, or any of your or his family members have the inherited diseases listed below. Indicate which family member has the disease.

Anencephaly	Yes	No	Learning Disabilities/ADD/ADHD	Yes	No
Aplastic Anemia	Yes	No	Limb Defects (fingers/toes etc)	Yes	No
Blindness (born with)	Yes	No	Mental Illness/Mental Disorders	Yes	No
Birth Defect	Yes	No	Muscular Dystrophy	Yes	No
Chromosome abnormality	Yes	No	Myotonic Dystrophy	Yes	No
Cleft lip/palate	Yes	No	Neurofibromatosis	Yes	No
Congenital cataracts	Yes	No	Neurologic or Degenerative Disease	Yes	No
Cystic Fibrosis	Yes	No	(i.e. myasthenia gravis/MS,Parkinson's)		
Deafness	Yes	No	PKU (Phenylketonuria)	Yes	No
Down syndrome	Yes	No	Sickle Cell Anemia	Yes	No
Epilepsy or Seizures	Yes	No	Skeletal Problems	Yes	No
Genetic disease	Yes	No	(i.e. dwarfism/ Charcot-Marie-Tooth)		
Heart Defect	Yes	No	Skin Disease	Yes	No
Hemophilia	Yes	No	Spina Bifida	Yes	No
Huntington's chorea	Yes	No	Tay-Sachs Disease	Yes	No
Hydrocephalus	Yes	No	Thalassemia	Yes	No
Kidney disease (polycystic)	Yes	No	Urinary tract disease requiring surgery	Yes	No

Have you or the father of your baby every had a child born dead or alive with a brain defect not listed above Yes No **If yes, explain**____

Do you or the father of your baby, or a close relative in either family, have any inherited genetic or chromosomal disease or disorder not listed above Yes No

If yes, explain____