SWOR WOMEN'S CARE
Gynecology • Obstetrics • Infertility • UroGynecology

G. Michael Swor, MD, FPMRS
Kelly-Anne Shedd-Hartman, DO, FACOOG
Jenny Lichon, DO
Holly Jackson, CNM
Allison Smith, APRN
Samantha McCormick, APRN

Obstetrical Health History Questionnaire

Name: _____ Date of Birth: _____
Address: _____
Local Phone Number: _____ Alternative Phone Number: _____

Parental Health History		
	Patient	Partner/ Father of Baby
Country of Birth		
Race		
Religion		
Education		
Occupation		
Significant Family Disease		
Mother of Baby: Pre- pregnancy weight: _____ Height: _____ Months Attempting pregnancy: _____		
Father of Baby: Full Name: _____ Phone Number: _____ Date of Birth: _____ Height: _____ Weight: _____		
Names and Ages of other Children		
Number of Previous C-Sections? _____ Reason for C-Section: _____		

Personal Health History		
Please check past or current problems or conditions		
□ Hypertension	□ Vomiting	□ Abnormal Uterus
□ Diabetes	□ Constipation	□ Phlebitis/ Varicose Veins
□ Asthma	□ Abdominal Pain	□ Accidents, specify:
□ Rh Negative Blood Type	□ Headache	□ Tuberculosis
□ Thyroid Dysfunction	□ Blood Transfusion history	□ Chemical/ Toxin exposure, specify:
□ Chicken pox or Varicella Vaccine (Circle one)	□ Liver Disease/ hepatitis	□ Radiation, specify:
□ Recurrent UTI	□ Other Viruses, Specify:	□ DES exposure
□ Urinary Complications	□ German Measles	□ Rheumatic Fever
□ Kidney Disease	□ Rash/Skin Lesions	□ Other:
What Age did you become sexually active? _____ Number of lifetime partners? _____		
Menstruation: First day of last period: _____ Length: _____ Occurs every: _____ days Normal □Yes □No		
How did you hear about us? ☺		
Date of last pap? _____ Normal? _____ Abnormal? _____		

Social History	
Marital Status	□ Single □Married/ Life Partner (years together)_____ □Divorced □Widowed
Do you live here year around? □ Yes □No If no, part time location: _____	
Tobacco use: □ Never □Quit (when) _____ □ Current smoker: Packs/ day, how many years? _____	
Do you have pets? □Yes □No If yes, What type(s): _____	
Alcohol use? □ Never □ Past □ Current how many drinks/ how often? _____	
Illicit drug use (including marijuana, cocaine, steroids): □Never □Past □Current □Describe: _____	

Obstetrical Health History			
Total Number of Pregnancies: _____	Full Term or Pre-term? _____	Elective Abortions:_____ Number of weeks pregnant:_____	Number of Living Children:_____
Spontaneous Miscarriages:_____ D&C Required? _____	Ectopic: Right or Left side?	Multiple gestation (twins,triplets,etc):	

Date of Delivery	Place of Delivery	Weeks Gestation	Gender	Hours in Labor	Weight of Baby	Type of Delivery	Anesthesia	Comments	Complications with baby

Additional Health History		
Please answer the following question:	Yes	No
Will you be 35 or older at the estimated date of delivery?		
Are you or the baby's father of Italian, Greek, or Mediterranean ancestry? (Circle one) If yes, have either of you been screened for B-Thalassemia? □Yes-Results: _____ □No		
Are you or the baby's father of Philippine or Southeast Asian ancestry? (Circle one) If yes, have either of you been screened for the A-Thalassemia? □Yes-Results: _____ □No		
Do you or the baby's father have a family history of any of the following? (please circle who) □ Down Syndrome □ A Chromosomal abnormality □ Neural Tube Defect (i.e., spina bifida, anencephaly, or hydrocephalus) □ Hemophilia □ Muscular Dystrophy □ Cystic Fibrosis □ Fragile X □ Huntington's Chorea □ Autism		
Do you have a history of congenital heart defect?		
Are you or the baby's father of Jewish ancestry? (please circle who) If yes, have either of you been screened for Tay-Sachs disease? □Yes-Results: _____ □No		
Do you have a history of Canavan Disease?		
Are you or the baby's father of African ancestry? If yes, have either of you been screened for sickle cell trait? □Yes-Results: _____ □No		
Do you have a history of Hemophilia or Other Blood Disorders?		
Do you have a history of rejection as a blood donor?		
Have you or your partner had a blood transfusion?		
Do you have a history of Muscular Dystrophy?		
Do you or your baby's father have any close relatives with mental retardation or autism? If yes, who is the relative: _____		
Have you or your baby's father had a child born with a defect not mentioned above?		
Have you or the baby's father had a chromosomal study? If yes, who and what are the results? _____		
Do you have parents or siblings with diabetes? If so, Type I or II?		
Do you have a history of recurrent pregnancy loss or still birth?		
Do you live with or exposed to someone with Tuberculosis?		
Do you or your baby's father have a history of Genital Herpes?		
Have you had a rash or viral illness since your last menstrual period?		
Do you have a history of STD, Gonorrhea, Chlamydia, HPV or Syphilis?		
Are you or a household member exposed to a Hepatitis carrier or Hemodialysis patient?		
During previous pregnancies, was your GBS culture positive? If yes, Did you have treatment during delivery? □ Yes □ No		
Do you have a history of acute liver disease?		
Do you have occupational exposure to blood in a medico-dental setting?		

Additional Health History (continued)		
Please answer the following questions:	Yes	No
Have you or your partner used injectable “street drugs”? (please circle who)		
Are you or your partner Bisexual? (please circle who)		
Have you had a child with a birth weight of 9lbs or more?		
Are you of Asian, Pacific Island or Alaskan Eskimo Decent?		
Were you born in Haiti or Sub-Saharan Africa?		
Do you have a history of Glycosuria (sugar in the urine)?		
Are you and your baby’s father first cousins or closely related?		
Are you currently taking prenatal Vitamins? If yes, what brand/ type? _____		
Excluding Iron and Vitamins, have you taken any medication or recreational drugs since being pregnant and/or since your last menstrual period?_____		
Thought About delivery & Afterwards		
What is your ideal method for pain control during your delivery?		
What Pediatrician do you plan to see?		
If you are having a boy, are you considering circumcision?	Yes	No
Do you plan on breast or bottle feeding? (Circle your choice)		
Pleas list ALL medications and the time taken during pregnancy ● _____ ● _____ ● _____		

Allergies	
Please list any allergies to medications, foods or materials (including latex)	
□ No Known Drug Allergies	Symptom/ Reaction
Name Of Allergies:	

Additional Providers	
Primary Care Provider	Other (ex: chiropractor, acupuncturist, ect.)
Name:	Name:
Phone: _____ Last seen:_____	Phone: _____ Last seen:_____
Other	Other
Name:	Name:
Phone: _____ Last seen:_____	Phone: _____ Last seen:_____

Immunizations
Please list any vaccines you have received with the date/year received (including annual influenza)

Special Communication Needs
Language Preference:

If “Yes” to any of the questions below, How can we assist?

Visual Impairment	□Yes □No	_____
Hearing Impairment	□Yes □No	_____
Speech Impairment	□Yes □N	_____
Cognitive Impairment	□Yes □No	_____
Sensory Impairment	□Yes □No	_____

Are there any religious or cultural factors that you would like us to take into account when planning your healthcare?
_____

Do you wish to have (NIPT) non-invasive Prenatal Testing* (optional testing) □Yes □No

Patient Signature: _____ Date: _____

My Birthing Log

Please describe, in your words, the positive aspects of your last birth(s).
Please describe the negative aspects of your last birth(s).
What would you like to do differently during your next delivery?