



Gynecology • Obstetrics • Infertility • Urogynecology

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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 <u>past</u> or <u>current</u> problems or conditions		
<input type="checkbox"/> Hypertension	<input type="checkbox"/> Vomiting	<input type="checkbox"/> Abnormal Uterus
<input type="checkbox"/> Diabetes	<input type="checkbox"/> Constipation	<input type="checkbox"/> Phlebitis/ Varicose Veins
<input type="checkbox"/> Asthma	<input type="checkbox"/> Abdominal Pain	<input type="checkbox"/> Accidents, specify: _____
<input type="checkbox"/> Rh Negative Blood Type	<input type="checkbox"/> Headache	<input type="checkbox"/> Tuberculosis
<input type="checkbox"/> Thyroid Dysfunction	<input type="checkbox"/> Blood Transfusion history	<input type="checkbox"/> Chemical/ Toxin exposure, specify: _____
<input type="checkbox"/> Chicken pox or Varicella Vaccine	<input type="checkbox"/> Liver Disease/ hepatitis	<input type="checkbox"/> Radiation, specify: _____
<input type="checkbox"/> Recurrent UTI	<input type="checkbox"/> Other Viruses, Specify: _____	<input type="checkbox"/> DES exposure
<input type="checkbox"/> Urinary Complications	<input type="checkbox"/> German Measles	<input type="checkbox"/> Rheumatic Fever
<input type="checkbox"/> Kidney Disease	<input type="checkbox"/> Rash/Skin Lesions	<input type="checkbox"/> Other: _____
What Age did you become sexually active? _____ Number of lifetime partners? _____		
Menstruation: First day of last period: _____ Length: _____ Occurs every: _____ days Normal <input type="checkbox"/> Yes <input type="checkbox"/> No		
How did you hear about us? ☺ _____		
Date of last pap? _____ Normal? _____ Abnormal? _____		
Social History		
Marital Status	<input type="checkbox"/> Single <input type="checkbox"/> Married/ Life Partner (years together) _____ <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed	
Do you live here year around? <input type="checkbox"/> Yes <input type="checkbox"/> No If no, part time location: _____		
Tobacco use: <input type="checkbox"/> Never <input type="checkbox"/> Quit (when) _____ <input type="checkbox"/> Current smoker: Packs/ day, how many years? _____		
Do you have pets? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, What type(s): _____		
Alcohol use? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, how many drinks/ how often? _____		
Illicit drug use (including marijuana, cocaine, steroids): <input type="checkbox"/> Never <input type="checkbox"/> Past <input type="checkbox"/> Current <input type="checkbox"/> Describe: _____		

Your Home for Women's Health

1900 South Tuttle Avenue Sarasota, Florida 34239

Phone: 941-330-8885 Fax: 941-906-8774

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
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 acute liver disease?									
Do you work in or receive treatment in a hemodialysis unit?									
Do you have a history of rejection as a blood donor?									
Have you or your partner had a blood transfusion?									
Do you have occupational exposure to blood in a medico-dental setting?									
Do you have household contact who is a hepatitis carrier or hemodialysis patient?									
In the last five years, have you had a sexual relationship with a partner that may have had a sexually transmitted disease?									
Have you or your partner used injectable "street drugs"?									
Are you or your partner bisexual?									
Do you have parents or siblings with diabetes? If so, Type I or II?									
Have you had a child with a birth weight of 9lbs or more?									
Do you have a history of Glycosuria (sugar in the urine)?									
Do you or the baby's father have a family history of any of the following? <input type="checkbox"/> Down Syndrome <input type="checkbox"/> A Chromosomal abnormality <input type="checkbox"/> Neural Tube Defect (i.e., spina bifida, anencephaly, or hydrocephalus) <input type="checkbox"/> Hemophilia <input type="checkbox"/> Muscular Dystrophy <input type="checkbox"/> Cystic Fibrosis <input type="checkbox"/> Huntington's Chorea									
Have you or your baby's father had a child born with a defect not mentioned above?									
Do you or your baby's father have any close relatives with mental retardation? If yes, relation: _____									
Are you and the baby's father first cousins or more closely related?									
Have you or the baby's father had a chromosomal study? If yes, who and what were the results? _____									
Are you or the baby's father of Jewish ancestry? If yes, have either of you been screened for Tay-Sachs disease? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, what were the results? _____									
Are you or the baby's father of African ancestry? If yes, have either of you been screened for sickle cell trait? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, What were the results? _____									
Are you or the baby's father of Italian, Greek, or Mediterranean ancestry? If yes, have either of you been screened for B-Thalassemia? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, what were the results? _____									

Additional Health History (continued)		
Please answer the following questions:	Yes	No
Are you or the baby's father of Philippine or Southeast Asian ancestry? If yes, have either of you been screened for the A-Thalassemia? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, what were the results? _____		
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)		
Please list ALL medications and the time taken during pregnancy		
• _____		
• _____		
• _____		
• _____		
Allergies		
Please list any allergies to medications, foods or materials (including latex)		
<input type="checkbox"/> 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	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
Hearing Impairment	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
Speech Impairment	<input type="checkbox"/> Yes <input type="checkbox"/> N	_____
Cognitive Impairment	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
Sensory Impairment	<input type="checkbox"/> Yes <input type="checkbox"/> 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)	<input type="checkbox"/> Yes	<input type="checkbox"/> 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?