

OB EMR Health History Questionnaire Form

Patient Name: _____

Birthdate: _____

Preferred Name: _____

Social History

Religion: _____

Occupation: _____

Planned Pregnancy: Yes No

Hospital of Delivery: Good Sam ST Vincent

Pediatrician : _____

Name of baby's father: _____

Age: _____

Occupation: _____

Menstrual History

Date of last menstrual cycle: _____

Date of last menstrual cycle reliability: Sure Unsure

Menstrual Periods: Regular Irregular

Interval between periods (days): _____

Duration of period (days): _____

Type of birth control used: _____

Date stopped: _____

Pregnancy Test

Home Pregnancy Test Taken: Yes No

Date taken: _____

OB History

Total Pregnancy: _____ Deliveries: _____

Miscarriages/Abortions: _____

Past Pregnancy History

Pregnancy 1

Delivery Date: _____ Birth Weight: _____ Gender: Male Female Name: _____

Complications: _____

Pregnancy 2

Delivery Date: _____ Birth Weight: _____ Gender: Male Female Name: _____

Complications: _____

Pregnancy 3

Delivery Date: _____ Birth Weight: _____ Gender: Male Female Name: _____

Complications: _____

Pregnancy 4

Delivery Date: _____ Birth Weight: _____ Gender: Male Female Name: _____

Complications: _____

Pregnancy 5

Delivery Date: _____ Birth Weight: _____ Gender: Male Female Name: _____

Complications: _____

Pregnancy 6

Delivery Date: _____ Birth Weight: _____ Gender: Male Female Name: _____

Complications: _____

Pregnancy 7

Delivery Date: _____ Birth Weight: _____ Gender: Male Female Name: _____

Complications: _____

Pregnancy 8

Delivery Date: _____ Birth Weight: _____ Gender: Male Female Name: _____

Complications: _____

Pregnancy 9

Delivery Date: _____ Birth Weight: _____ Gender: Male Female Name: _____

Complications: _____

Pregnancy 10

Delivery Date: _____ Birth Weight: _____ Gender: Male Female Name: _____

Complications: _____

Current Active Problems (i.e. hypothyroid, depression, hypertension, diabetes)

Type _____

Previous Hospitalizations, Surgery, Serious Injury

Type _____ Year _____

Current Prescriptions / Supplements / Over the Counter Medications:

Name	Dose	Name	Dose
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Pap History

Last Pap Smear: _____ Normal Abnormal
History of Abnormal Pap Smear: Yes No History of Bacterial Vaginosis: Yes No
History of Recurring Yeast Infection: Yes No History of Cervical Treatment: Yes No

STD History

Chlamydia: Yes No
Gonorrhea: Yes No
Hepatitis B: Yes No
Hepatitis C: Yes No
Genital Herpes: Yes No
HIV/AIDS: Yes No
Syphilis: Yes No
Trichomoniasis: Yes No
PID: Yes No
Condyloma/Warts: Yes No
Pubic Lice: Yes No
HPV: Yes No

Comments:

Partner Question

	Yes	No	Comments
Has your sexual partner ever had an STD	Yes	No	_____
Have any of your male partners ever had sex with another male	Yes	No	_____
Has your sexual partner every used IV street drugs	Yes	No	_____
Has any of your sexual partners had HIV or AIDS	Yes	No	_____
Has your sexual partner ever had a blood transfusion	Yes	No	_____
Have you ever had sex with 2 or more partners at one time	Yes	No	_____

Habits and Exposures

	Yes	No	Comments
Have you had any x-rays during this pregnancy	Yes	No	_____
Have you had any alcohol during this pregnancy	Yes	No	_____
Alcohol Prior to Pregnancy: Yes No	Amount: _____	Daily Weekly Monthly	
Caffeine Use: Yes No	Amount: _____	Daily Weekly Monthly	
Exercise: Yes No	Type: _____	Duration (min): _____	Daily Weekly Monthly
Smoking/Tobacco Use: Yes No	Year Started: _____	Amount: _____	Daily Weekly Monthly

Have you taken any OTC, Rx or street drugs during this pregnancy Yes No _____
Current drug use Yes No _____
History of drug use Yes No _____

Type

Safety/Abuse Questions

Do you feel safe in your personal relationships	Yes	No	_____
Do you feel safe in your home	Yes	No	_____
Do you feel safe in your own neighborhood	Yes	No	_____
Have you ever been physically hurt by someone	Yes	No	_____
Have you experienced uncomfortable touching or forced sexual contact	Yes	No	_____
Have you ever had your feelings repeatedly hurt, put down or other kinds of hurts	Yes	No	_____

Comments

Family History

	Yes	No	Type/Relationship
Diabetes	Yes	No	_____
Heart Disease	Yes	No	_____
Hypertension	Yes	No	_____
Renal Disease	Yes	No	_____
Lung Disease	Yes	No	_____
Seizures Disorders	Yes	No	_____
Cervical Cancer	Yes	No	_____
Ovarian Cancer	Yes	No	_____
Uterine Cancer	Yes	No	_____
Breast Cancer	Yes	No	_____
Colon Cancer	Yes	No	_____
Other Cancer	Yes	No	_____
Birth Defects and Hereditary	Yes	No	_____
Multiple Births	Yes	No	_____
Congenital Anomaly	Yes	No	_____
Chromosome Abnormality	Yes	No	_____
Cystic Fibrosis	Yes	No	_____
Other	Yes	No	_____

Genetic History

	Self		Father of the Baby		Comments
Thalassemia	Yes	No	Yes	No	_____
Neural Tub Defect	Yes	No	Yes	No	_____
Down Syndrome	Yes	No	Yes	No	_____
Tay-Sachs	Yes	No	Yes	No	_____
Sickle Cell Disease/Trait	Yes	No	Yes	No	_____
Hemophilia	Yes	No	Yes	No	_____
Muscle Dystrophy	Yes	No	Yes	No	_____
Cystic Fibrosis	Yes	No	Yes	No	_____
Huntington's Disease	Yes	No	Yes	No	_____
Mental Retardation	Yes	No	Yes	No	_____
Fragile X	Yes	No	Yes	No	_____
Other Genetic/Chromosomal	Yes	No	Yes	No	_____
Child with Other Birth Defects	Yes	No	Yes	No	_____
>3 Spontaneous Abortion	Yes	No	Yes	No	_____
History of Stillbirth	Yes	No	Yes	No	_____
Caucasian	Yes	No	Yes	No	_____
Asian/Pacific Islander	Yes	No	Yes	No	_____
African American	Yes	No	Yes	No	_____
Hispanic/Latin	Yes	No	Yes	No	_____
Middle Eastern	Yes	No	Yes	No	_____
Native American	Yes	No	Yes	No	_____
Mediterranean	Yes	No	Yes	No	_____
Jewish	Yes	No	Yes	No	_____

Drug Allergies:

Yes / No		Name	Reaction
Name	Reaction	Name	Reaction
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____