Date______

CAPITAL WOMEN'S CARE
OBSTETRICAL QUESTIONNAIRE

Patient Name____ Age________ Date of Birth___________
Chief Complaint____

ALLERGIES

Name of Drug	Reaction

MEDICATIONS

Name of Drug	Prescribed for

OBSTETRICAL HISTORY

Full Term______ Premature______ Abortions/Miscarriages______ Ectopic_____ Living Children______

No.	Date	Sex	WT.	Duration Of Preg.	Duration of Labor	Type of Delivery	Anesthesia	Complications

MEDICAL HISTORY

1. Diabetes Yes No
2. Hypertension Yes No
3. Heart Disease Yes No
4. Autoimmune Disorder Yes No
5. Kidney Disease/UTI Yes No
6. Neurologic/epilepsy Yes No
7. Psychiatric Yes No
8. Depression/postpartum Yes No
9. Hepatitis/liver disease Yes No
10. Varicosities/phlebitis Yes No
11. Thyroid dysfunction Yes No
12. Trauma/violence Yes No
13. Blood transfusions Yes No
14. D (Rh) sensitive Yes No
15. Varicella (chicken pox) Yes No
16. Pulmonary (TB, Asthma) Yes No
17. Seasonal allergies Yes No
18. Drug/Latex Allergies Yes No
19. Breast Problems Yes No
20. GYN surgery (List below) Yes No
21. Operation/hosp.(List below) Yes No
22. Anesthetic complications Yes No
23. History of abnormal PAP Yes No
24. Uterine Anomaly Yes No
25. Infertility Yes No
26. ART Treatment Yes No
27. Relevant History Yes No
28. Cats (as pets) Yes No

GYNECOLOGICAL HISTORY

Last Menstrual Period ______________________ Cycle Regular? ◯Yes ◯No Frequency ___________________

Definite? ◯Yes ◯No ◯Unknown Normal Amount/Duration? ◯Yes ◯No Prior Menses _________________

Were you on Birth Control Pills when you conceived? ◯Yes ◯No First date of positive HPT ________________

	Pre-pregnancy amount/packs per day	Pregnant amount/packs per day	# of years of use
Tobacco			
Alcohol			
Caffeine			
Recreational Drugs			

INFECTION HISTORY

1. Live with someone with TB or exposed to TB Yes No
2. Patient or partner has history of genital herpes (please circle patient/partner) Yes No
3. Rash of viral illness since LMP Yes No
4. Hepatitis B or C (Please circle Type) Yes No
5. Circle if history of any of the following:
   HPV Gonorrhea HIV Chlamydia Syphilis

Past Medical History	Date

Past Surgical History	Date

Family History of Disease	Family Member

CAPITAL WOMEN'S CARE
GENETIC COUNSELING/TERATOLOGY COUNSELING

Patient Name: ____ Date: _________________

Father of Baby Name___________________________________ Phone Number____________________

1. Patient's age 36 years or older as of estimated date of delivery	Yes	No
2. Thalassemia (Italian. Greek, Mediterranean or Asian background)	Yes	No
3. Neural Tube Defects (meningomyelocele, spina bifida or anencephaly)	Yes	No
4. Congenital heart defect	Yes	No
5. Down Syndrome	Yes	No
6. Tay Sachs (Ashkenazi Jewish, Cajun, French Canadian)	Yes	No
7. Canavan Disease (Ashkenazi Jewish)	Yes	No
8. Familial dysautonomia (Ashkenazi Jewish)	Yes	No
9. Sickle Cell disease or trait (African)	Yes	No
10. Hemophilia or other blood disorders	Yes	No
11. Muscular dystrophy	Yes	No
12. Cystic fibrosis	Yes	No
13. Huntington's chorea	Yes	No
14. Mental Retardation/autism	Yes	No
15. Other inherited genetic or chromosomal disorder	Yes	No
16. Maternal metabolic disorder (e.g.: Type 1 Diabetes, PKU)	Yes	No
17. Patient or baby's father had a child with birth defects not listed above	Yes	No
18. Recurrent pregnancy loss or a stillbirth	Yes	No
19. Medications (including supplements, vitamins, herbs, or OTC drugs/ Illicit/rec. drugs/alcohol since LMP	Yes	No

If yes, agent and strength/dosage:

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