**CAPITAL WOMEN’S CARE**

**OBSTETRICAL QUESTIONNAIRE**

Patient Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Age\_\_\_\_\_\_\_\_ Date of Birth\_\_\_\_\_\_\_\_\_\_

Chief Complaint\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**ALLERGIES**

|  |  |
| --- | --- |
| Name of Drug | Reaction |
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**MEDICATIONS**

|  |  |
| --- | --- |
| Name of Drug | Dose/Frequency of Administration |
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|  |  |
|  |  |
|  |  |

**PAST 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 |
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**GYNECOLOGICAL HISTORY**

Last Menstrual Period\_\_\_\_\_\_\_\_\_Last Pap Smear\_\_\_\_\_\_\_\_\_\_Last Mammogram\_\_\_\_\_\_\_\_\_

Age began menstrual period\_\_\_\_\_\_

Cycle frequency\_\_\_\_\_\_\_\_Duration (# of days)\_\_\_\_\_\_Type of birth control\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**MEDICAL HISTORY**

1.Diabetes Yes No 18. Pulmonary (TB, Asthma) Yes No

2.Hypertension Yes No 19. Seasonal allergies Yes No

3.Heart Disease Yes No 20. Drug/Latex Allergies Yes No

4.Autoimmune Disorder Yes No 21. Breast problems Yes No

5.Kidney Disease/UTI Yes No 22. Gyn Surgery (List Below) Yes No

6.Neurologic/epilepsy Yes No 23. Operation/Hosp. (List Below) Yes No

7.Psychiatric Yes No 24. Anesthetic complications Yes No

8.Depression/postpartum Yes No 25. History of abnormal pap Yes No

9.Hepatitis/liver disease Yes No 26. Uterine anomaly/DES Yes No

10.Varicosities/phlebitis Yes No 27. Infertility Yes No

11.Thyroid dysfunction Yes No 28. ART Treatment Yes No

12.Trauma/violence Yes No 29.Relevant Hisotry Yes No

13.Blood transfusions Yes No 30. H/o chickenpox or Vaccine Yes No

17.D(Rh) sensitive Yes No 31. Cats (as pets) Yes No

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| --- | --- | --- | --- |
|  | Pre-pregnancy  amount/packs per day | Pregnant  amount/packs per day | # of years of use |
| 14. Tobacco |  |  |  |
| 15. Alcohol |  |  |  |
| 16. Recreational Drugs |  |  |  |
| Caffeine |  |  |  |

**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

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| **Past Medical History** | **Date** |
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| **Past Surgical History** | **Date** |
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| **Family History of Disease** | **Family Member** |
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**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.Developmental delay/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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