CUMC Department of Obstetrics and Gynecology
Division of Maternal Fetal Medicine

Name: _____
MRN: _____ DOB: _____

**Obstetrical History Questionnaire***

| Total # of Pregnancies | # of Term Births (>37 wks) | # of Premature Births (<37 wks) | # of Abortions | # of Miscarriages | # of Ectopic Pregnancies | # of Living Children |
|---|---|---|---|---|---|---|
| | | | | | | |

**Past Pregnancies (# should equal total # of pregnancies listed above)***

| # | Month/Yr | Birth/ Miscarriage/ Termination/ Ectopic | Wks Pregnant | Birth Wt | Sex | Delivery Type: Vaginal, Forceps, C-Section, Vacuum, VBAC, D&C, Medical Rx, Laparoscopic Rx | Place of Delivery | Comments/Complications |
|---|---|---|---|---|---|---|---|---|
| 1 | | | | | | | | |
| 2 | | | | | | | | |
| 3 | | | | | | | | |
| 4 | | | | | | | | |
| 5 | | | | | | | | |

***Please continue on back side of page for any additional Past Pregnancies**

**Medical History**

| Condition | Y/N | Condition | Y/N | Condition | Y/N |
|---|---|---|---|---|---|
| Asthma | | Diabetes | | Seizures/Convulsions/Epilepsy | |
| Pneumonia | | High Blood Pressure | | Gastrointestinal Problems | |
| Chronic Lung Disease | | Stroke | | Glaucoma | |
| Tuberculosis | | Rheumatic Fever | | Arthritis/Joint pain | |
| Kidney Disease | | Cancer | | Fracture | |
| Sexually Transmitted Infections | | Ulcers | | Hepatitis/Liver Disease | |
| Heart Trouble/Murmur | | Depression/Anxiety | | Thyroid Disease | |
| Other: _____ | | Anemia/Blood Transfusions | | Other: _____ | |

**Family History (List any relatives that have the following conditions)***

| Condition | Kinship & Relationship (ie. Maternal Grandmother, Father) | Condition | Kinship & Relationship (ie. Maternal Grandmother, Father) |
|---|---|---|---|
| Diabetes | | Cancer | |
| High Blood Pressure | | Psychiatric | |
| Heart Disease | | Other | |

**Genetic Screening (Mark 'M' for Mother's ethnic backgrounds and 'F' for Baby's Father's ethnic backgrounds)**

| Ethnic Origin | M | F | Ethnic Origin | M | F | Ethnic Origin | M | F |
|---|---|---|---|---|---|---|---|---|
| Ashkenazi Jewish | | | Asian | | | Other: _____ | | |
| Sephardic Jewish | | | Italian | | | | | |
| French Canadian | | | Greek | | | | | |
| Caucasian | | | Middle Eastern | | | | | |
| African American, African or Black | | | Hispanic | | | | | |

**Please continue to page 2: Genetic Risk Assessment, Surgeries & Hospitalizations, Medications, and Allergies.**



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Name: _____
MRN: _____ DOB: _____

**Genetic Risk Assessment (Mark 'M' if Mother, 'F' Baby's Father, 'MF' Mothers Family, 'FF' Fathers Family)**

| Condition | M/F/MF/FF | Condition | M/F/MF/FF |
|---|---|---|---|
| Neural Tube Defect (Meningomyelocele, Spina Bifida or Anencephaly) | | Cystic Fibrosis | |
| Congenital Heart Defect | | Mental Retardation/Autism | |
| Down Syndrome | | Maternal Metabolic Disorder (eg, Type 1 Diabetes, PKU) | |
| Genetic Metabolic Disorder | | Recurrent Pregnancy Loss, or a Stillbirth | |
| Sickle Cell Disease or Trait | | Other Birth Defects | |
| Thalassemia | | Other Single Gene Disorders | |
| Hemophilia or Other Blood Disorders | | Consanguinity | |
| Muscular Dystrophy | | Other | |

**Surgeries & Hospitalizations***

| # | Date | Procedure | Diagnosis/Reason | Hospital Name |
|---|---|---|---|---|
| 1 | | | | |
| 2 | | | | |
| 3 | | | | |
| 4 | | | | |
| 5 | | | | |

**Current Medications (Include any vitamins and herbal supplements)**

| | Medication Name | Dosage & Frequency | | Medication Name | Dosage & Frequency |
|---|---|---|---|---|---|
| 1 | | | 4 | | |
| 2 | | | 5 | | |
| 3 | | | 6 | | |

**Allergies (include all medication and non-medication allergies)***

| Allergen | Symptoms | Allergen | Symptoms |
|---|---|---|---|
| | | | |
| | | | |
| | | | |

**Preferred Pharmacy***

| Name | Address | City | State | Zip Code | Telephone | Mail Order/Retail? |
|---|---|---|---|---|---|---|
| | | | | | | |
| | | | | | | |

**Please continue to page 3: Social History**



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Name: _____
MRN: _____ DOB: _____

## Social History

Pt

Occupation _____ Marital Status _____

Father of Baby Name _____ FoB/Partner Occupation _____

**Exercise**

How often do you exercise per week? _____ Type of Exercise _____

**Alcohol/Smoking/Drug Use**

Do you smoke or use tobacco? _____ # of packs per day _____ Years Smoked _____

Are you exposed to 2nd hand smoke at home or work? _____

Do you consume alcohol? _____ # of drinks per day/week _____ Type of alcohol _____

Do you use recreational drugs? _____ # per day/week _____ Type of drug(s) _____

**Diet/Habits**

List any dietary restrictions _____

Have you ever been threatened, abused or hurt by anyone? _____

Will you accept blood products in an Emergency? _____

**Advanced Directives**

Do you have an advanced directive or living will? _____

Do you have a durable power of attorney? _____

Do you have a do not resuscitate document? _____

## Gynecological History

Date of last menstrual period _____ Age of 1st period _____

Are your periods regular? _____ How many days does your period last? _____

When was your last pap smear? _____ Have you ever had an abnormal pap smear? _____

When was your last mammogram? _____ Do you perform self breast exams? _____

Have you ever been treated for any of the following? (Circle)

Vaginosis Genital warts Chlamydia Herpes Trichomonas Gonorrhea Syphilis

Have you ever tested positive for HIV? _____ Did your mother take DES when she was pregnant with you? _____



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