

Name: _____



Initial OB Visit Questionnaire

Thank you for choosing Sound Family Medicine for you and your newborn's health care. During an initial OB visit, we like to run a screening process to check for potential illness and review your background history with you for further care during pregnancy.

Mother's Personal Information

1. Where did you have your initial pregnancy test performed?

Home Sound Family Medicine Other Clinic/Medical Facility (please list) _____

2. What was the date of your positive pregnancy test? ____/____/____

3. How many children currently live with you at your home? _____

4. What do you consider your marital status to be?

Married Separated Divorced Single

5. What is your current occupation? _____

6. What is the highest level of education you have completed?

Grade School Some High School High School
Some College College Graduate School

7. What do you consider your racial background to be?

Caucasian
Asian/Pacific Islander
American Indian/Alaskan Native
African American
Hispanic/Latino

Father's Personal Information

What is the name of the child's father? _____

Name: _____

Menstrual (Period) History

1. What was the first day of your last menstrual period? ___/___/20__

2. Do you consider your last menstrual period to be normal (similar to other menstrual cycles)?

Yes No (please explain) _____

3. How many days did your last menstrual period last? _____

4. How many days are typically between your menstrual cycles? _____

5. At what age did you first have menstrual cycles? _____

6. Were you taking any type of contraceptive at the time of the child's conception?

Yes No (please list name of medication) _____

8. Have you had any of these symptoms since your last period? *(please circle all that apply)*

Nausea Vomiting Fatigue Irritability

Bloating Breast Tenderness Urinary Frequency

9. Do you have any other symptoms you would like to discuss?

Previous Pregnancy History

1. How many times have you been pregnant? _____

2. How many of your pregnancies were "live births"? _____

(Live birth means that you completed your pregnancy and delivered your child.)

3. How many of your pregnancies were miscarriages? _____

4. How many of your pregnancies were abortions? _____

5. How many of your pregnancies were delivered via c-section? _____

6. How many of your pregnancies were delivered vaginally? _____

7. Have you had any vaginal deliveries after a c-section?

Yes No Not Applicable

Name: _____

Personal Medical History

1. Have you ever had any major surgeries or injuries?

No Yes (please explain) _____

2. Do you currently have, or have you ever had, any of the following? *(Please circle all that apply)*

- Asthma
- Anemia
- ADD/ADHD
- Diabetes
- Hypertension
- Hypothyroidism
- Hyperthyroidism
- Hepatitis
- Urinary Tract Infection

Family Medical History

Do you or the child's father have a family history of...

**Please check all diagnoses that apply to your family history.*

	MOTHER	FATHER
Alcoholism:	_____	_____
Arthritis:	_____	_____
Asthma:	_____	_____
Cancer:	_____	_____
Heart Disease:	_____	_____
Depression:	_____	_____
Diabetes:	_____	_____
Stroke:	_____	_____
Hypertension:	_____	_____
Hyperlipidemia:	_____	_____
Migraine:	_____	_____
Osteoporosis:	_____	_____
Seizures:	_____	_____
Thyroid Disease:	_____	_____
Learning Disabilities:	_____	_____
ADD/ADHD:	_____	_____

Name: _____

Genetic History

Do you or the child's father have a family history of...

**Please check all diagnoses that apply to your family history.*

	MOTHER	FATHER
Thalassemia:	_____	_____
Neural tube defect:	_____	_____
Down's Syndrome:	_____	_____
Tay-Sach's Disease:	_____	_____
Sickle Cell Disease/Trait:	_____	_____
Hemophilia:	_____	_____
Muscular Dystrophy:	_____	_____
Cystic Fibrosis:	_____	_____
Huntington's Disease:	_____	_____
Mental Retardation:	_____	_____
Fragile X:	_____	_____
Other Genetic/Chromosomal Disease?	_____	_____
Child with other birth defect?	_____	_____
More than 3 miscarriages?	_____	_____
History of stillbirth?	_____	_____
Please list any other genetic information		

Have you seen a genetic counselor?

Yes No

If Yes, please provide the name of the clinic and telephone number if available:

Name: _____

Immunization/Infection History

1. Are you at high risk for Hepatitis B?
Yes No
2. Are you immunized against Hepatitis B?
Yes No
3. Have you had exposure to tuberculosis?
Yes No
4. Any history of STD (Gonorrhea, Chlamydia, Syphilis, HPV)?
Yes No
If Yes, please indicate the illness and the year of diagnosis. _____
5. Have you ever had a partner with a history of genital herpes?
Yes No
6. Have you had a rash, viral illness or fever since your last menstrual period?
Yes No
7. Any exposure to cat litter?
Yes No
8. Have you had chickenpox at any time?
Yes No
9. Have you had the varicella vaccine?
Yes No
10. Do you have a history of Parvovirus (Fifth's Disease)?
Yes No
11. Do you work in an environment with exposure to children?
Yes No

Environmental Exposures

- Any x-ray exposure since your last menstrual cycle?
Yes No
- Any hazardous chemical exposure?
Yes No
- Have you used tobacco since you had your positive pregnancy test?
Yes No
If Yes, how many cigarettes per day? _____
How long have you smoked? _____
- Have you consumed any type of alcohol since you had your positive pregnancy test?
Yes No
If Yes, how many drinks per week? _____
How long have you been drinking? _____
- Have you used any type of illicit drugs or substances since your positive test?
Yes No
If Yes, What type? _____