The Women's Medical Center

Ob Questionnaire

Name _____ Date _____

1. When was the first day of your last period? _____/_____/_____
2. Is this your first pregnancy? YES ____ NO ____ If **YES**, go to #3.

   How many times have you been pregnant (including your current pregnancy)? _____

   How many children do you have? _____

   Did you experience any of the following problems during or after your previous pregnancies?

   _____ Blood Transfusion
   _____ Cesarean section
   _____ Forceps/vacuum delivery
   _____ Gestational (pregnancy) diabetes
   _____ diet controlled
   _____ pills by mouth
   _____ insulin
   _____ Ectopic pregnancy
   _____ Elevated blood pressure or seizures
   _____ Growth restriction/small baby
   _____ Incompetent cervix/cerclage/need for progesterone injections
   _____ Large baby >/+ 9 lbs
   _____ Molar pregnancy
   _____ Placental abruptio/abnormal bleeding/hemorrhage
   _____ Postpartum depression
   _____ Preterm delivery before 37 weeks
   _____ Shoulder dystocia/broken clavicle/arm injury during delivery
   _____ Stillbirth

   Any other complication that we should know about? _____
3. Have you seen a doctor or been to the ER during THIS pregnancy? YES _____ NO _____

   If yes, which hospital? _____ Date(s) seen _____
4. Are you allergic to any medications? Please list _____ reaction _____
5. Check any medical problems you have.

   _____ Alcohol abuse
   _____ Asthma
   _____ Blood clots in your legs/lungs
   _____ Depression
   _____ Drug abuse
   _____ Genital herpes
   _____ Hepatitis
   _____ High blood pressure/hypertension
   _____ HIV
   _____ Kidney disease
   _____ Seizure/epilepsy
   _____ Sickle cell trait/disease
   _____ Stroke
   _____ Syphilis
   _____ Thyroid problems
6. List any medications that you take, include medications that you should be taking or stopped recently due to pregnancy. _____
7. Do you or the father of your baby or your families have any of the following?

   _____ Cystic Fibrosis
   _____ Down Syndrome
   _____ Heart defects
   _____ Mental retardation
   _____ Sickle Cell Disease/trait
   _____ Spina Bifida

   Please explain or list any birth defects not listed. _____
8. List any surgeries that you have had. _____
9. Do you have any religious objection to a blood transfusion YES _____ NO _____
10. How many doses of the COVID-19 Vaccine have you received? _____
11. Which pharmacy would you like to use? _____