Obstetrical Patient Questionnaire

Today's Date: _____Name: _____

Age: _____ Date of Birth (DOB) _____ Preferred Contact Number: _____

Email address: _____

Marital status: _____Your Occupation: _____

Partner's Name: _____their DOB: _____ Occupation: _____

Your Ethnicity: _____ Father (of baby) Ethnicity: _____

Language Spoken at home: _____

Emergency Contact – Name: _____Phone #:_____

***First day** of Last Normal Menstrual Period: _____ Are you sure of the date? Yes / No

My period comes every _____ days. Is your period regular and predictable? Yes / No

PREVIOUS PREGNANCIES: – Please include **ALL** pregnancies: (including, miscarriages & abortions)

Date (dd/mm/yyyy)	Hospital or City/ Country	Delivery Type (vaginal, C/S, forceps, vacuum,)	Complications (anemia, high BP, diabetes, labor issues, induced?)	Length of Labour (hours)	Boy or Girl?	Birth Wt.

Assisted Conception: Did you have medical help to get pregnant? Yes / No

What method was used? _____

PERSONAL MEDICAL INFORMATION:

Have **YOU ever had** or **do YOU currently have** any of the following conditions. Check All that apply.

	YES		YES
Any major injuries		Abnormal Pap test? Treatment?	
Are you Related to father of this baby (blood relation)		MENTAL Health (depression, anxiety, etc)	
Auto-immune disorders		Anesthetic problems?	
Diabetes (including previous pregnancies)		Asthma	
Easy bleeding or history of blood clots		Tuberculosis	
Epilepsy / Seizure Disorders		Birth Defects (i.e. hip dysplasia, cleft lip)	
Heart Disorders (i.e. murmurs, arrhythmias)		Blood transfusion? When?	
Hepatitis A ,B or C / liver disease		Chicken pox (Varicella) / **or** been vaccinated	
High Blood Pressure (including previous pregnancies)		Development (i.e. ADD, ADHD, FAS)	
HIV / AIDS		Hereditary conditions	
Kidney /Bladder Problem (i.e. infections/ stones)		Hypothyroid / Hyperthyroid (Thyroid)	
STI (herpes, chlamydia, syphilis, gonorrhea)		Migraines / **Severe** headaches	
Stomach Disorders (i.e. IBS, Crohns, celiac)		Other issues (not previously listed)	

Date of last physical exam _____ Pre-pregnancy weight _____ Height _____

List all hospital admissions and surgeries, including those as a child:

_____

_____

Current MEDICATIONS & dose: **(**Vitamins**,** Prescriptions, Over-the-Counter medications, Herbal treatments): _____

_____

Name of Pharmacy: _____

ALLERGIES/ INTOLERANCES: list medications and other substances and type of reaction:

_____

_____

FAMILY MEDICAL HISTORY:

Who in **YOUR FAMILY** or **THE FATHERS FAMILY** have any of the following medical problems?

Diabetes: _____

High Blood Pressure_____ Heart disease: _____

Twins: _____

Psychiatric – (i.e. Depression, Anxiety, Bipolar) _____

Auto immune disorders: (i.e. Thyroid, rheumatoid arthritis, MS) _____

Babies in the family Born with birth abnormalities _____

Hereditary Disorders_____

Disorders of the Blood / Clotting or bleeding problems: _____

Complications in pregnancy: _____

Other (i.e. hemophilia, chromosome disorders, thalassemia) _____

LIFESTYLE, SOCIAL, AND CULTURAL ISSUES:

1. Have you Smoked tobacco in the past year? Yes / No **If yes:** # of cigarettes per day _____ When was your last cigarette? _____
2. Have you consumed alcohol during this pregnancy? Yes / No. When was your last drink? _____
   Frequency of use**:** Daily **/** 2 – 3 times per week **/** once a week **/** Occasional. Average # of drinks?_____
3. Have you ever or are you currently taking recreational drugs? Yes / No
   Last used (date) _____ List: **ALL** recreational drugs / solvent(s) used: (current & in past**)**
   _____ / History of Addiction?: _____
4. Social/Cultural concerns: **(** i.e. Financial; Support System; Religious Beliefs; Relationship Stability; Domestic Violence, Other): _____
5. Environmental / Occupational concerns : (i.e. Second hand smoke, pets, toxins, other),_____
6. *Have you travelled outside of Canada in the past year? _____When?_____Where?_____
7. *Do you Plan to travel outside of Canada during this pregnancy? _____