OBSTECTRIC QUESTIONNAIRE

Today's Date _____
Patient Name _____ Date of Birth _____
Total number of pregnancies _____
Total number of live births _____
Number of miscarriages or abortions _____
Home pregnancy test date_____
Any birth control at time of conception _____

Delivery:

Month/Year	Vaginal, C-Section, Abortion	Weeks @ birth	Weight of baby	Gender	Any complications	Did you receive an Epidural

Past Hospitalization other than Deliveries (Surgery, Medical Diagnosis of any illness):
List month and year along with procedure:

Social History: (Prior or Current)

1. Alcohol Consumption:
   Amt/Day_____
   # of years Drinking_____
2. Tobacco Usage:
   Amt/Day_____
   # of years Smoking____
3. Recreational Drugs:
   Amt/Day_____
   # of years Usage_____

Family Medical History on Patient and Spouse side of the family (immediate):
Has anyone been diagnosed with the following, if so please list who it was:
Tuberculosis, Neuro Tube Defect, Congenital Heart Defect, Down Syndrome, Tay Sach, Cystic Fibrosis, Mental Retardation, Birth Defect, Sickle Cell Anemia, Muscular Dystrophy, Huntington's Corea, Autism.

Has patient been diagnosed or been exposed to:
Tuberculosis, Genital Herpes, Sexually Transmitted disease (Chlamydia, Gonorrhea, Syphilis, Trichomonas etc..), Hepatitis B or C.
