KAISER PERMANENTE®

Name

Health Record Number

Date of Birth

Today's Date

Obstetrical Questionnaire

Please complete this questionnaire before your first prenatal visit and mail it back in the provided envelope, or bring it with you. Your nurse midwife, nurse practitioner, or doctor will review the questionnaire with you and use it for your care.

General Information/OB Demographics (Please print)

Patient Information

Name:

Address: Street City State Zip Code

Phone: / / Age: Date of birth:
NIGHT (☐ HOME / ☐ WORK) DAY (☐ HOME / ☐ WORK) EMERGENCY PHONE #

Marital status: ☐ Married ☐ Single ☐ Widowed ☐ Divorced ☐ Separated ☐ Domestic Partner

Ethnic group/race: Religion:

Occupation: Years of education:

Who to contact in case of emergency: Relationship:

Emergency Contact Phone: /
NIGHT (☐ HOME / ☐ WORK) DAY (☐ HOME / ☐ WORK)

Spouse/Significant Other Information

Name of spouse/significant other:

Is this the father of baby: ☐ Yes ☐ No Age: Home Phone:

Ethnic group/race: Religion:

Occupation: Years of education:

Work phone:

Other Patient Information

How much did you weigh before this pregnancy? ☐ Don't know

OB MD: Planned hospital for delivery:

OB CNM/NP/PA: Site of prenatal care:

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Not to be filed in the Outpatient Paper Medical Record

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Menstrual History/Dating Information

1. First day of your last period: ☐ Definite ☐ Approximate ☐ Unknown

2. Was your period normal in number of days and flow? ☐ Yes, normal ☐ No, abnormal

3. Shortest number of days from first day of period to first day of the next period:
   Longest number of days from first day of period to first day of the next period:

4. Date of conception, if known:

5a. Method of birth control: ☐ None ☐ Pills ☐ Condom ☐ IUD ☐ Implanon ☐ Diaphragm
☐ Depo Provera injections ☐ Progesterone pill ☐ Natural family planning
☐ Other:

5b. When did you stop using this method?

6. Were you breastfeeding when your last period started? ☐ Yes ☐ No Date stopped:

7. Have you had a positive pregnancy test? ☐ Yes ☐ No Date:
   If yes, was it at ☐ Home ☐ Kaiser Permanente ☐ Other:

Previous Pregnancies (List all previous pregnancies, include miscarriages or abortions)
Specialty History: Obstetrics

MW	Date mo/day/yr.	How far along in weeks	No. of hours in labor	Weight of baby	Sex of baby	Type of delivery (vag or C/S)	Type of anesthesia	Preterm labor or pregnancy	Name of baby	Place where baby born	Problems with labor or delivery for you or baby?
1											
2											
3											
4											
5											
6											
7											
8											
9											
10											

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Past Medical/Surgical History

Yes	No	**Have you ever had:** (If yes, please explain and note date)
☐	☐	1. Diabetes (high blood sugar)?
☐	☐	2. Hypertension (high blood pressure)?
☐	☐	3. Asthma
☐	☐	4. Heart disease, mitral valve prolapse, or rheumatic fever?
☐	☐	5. Autoimmune disease such as lupus or rheumatoid arthritis?
☐	☐	6. Kidney disease, kidney infection, urinary tract, or many bladder infections?
☐	☐	7. Epilepsy or seizures?
☐	☐	8. Migraine headaches?
☐	☐	9. A stroke?
☐	☐	10. Other neurologic problems?
☐	☐	11. Treatment for depression?
☐	☐	12. Other psychiatric care?
☐	☐	13. Hepatitis, liver disease, or yellow jaundice?
☐	☐	14. Blood clots in your veins, deep venous thrombosis, inflammation in the veins, phlebitis, or pulmonary embolism?
☐	☐	15. Excessive bleeding after surgery or dental work?
☐	☐	16. Anemia?
☐	☐	17. Thyroid problems or taken thyroid medication?
☐	☐	18. Other endocrine problems?
☐	☐	19. A major accident or suffered serious trauma?
☐	☐	20. Within the last year has anyone hit, slapped, kicked or otherwise hurt you or do you feel unsafe at home?
☐	☐	21. Sex abuse or rape?
☐	☐	22. A blood transfusion?
☐	☐	23. Would you rather die than receive a blood transfusion?

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Alcohol/Tobacco/Drugs

	Amt/day before pregnant	Amt/day while pregnant	No. of years of use	Quit Date
24. Does anyone in your home smoke?				
25. Do you smoke or use chewing tobacco?				
26. Do you drink beer, wine, or hard liquor?				
27. Do you use any of the following: marijuana, speed, cocaine, heroin, hallucinogens, meth, or other drugs?				

28. **Allergies:** Which drugs or medicines are you allergic or sensitive to?

Drug	Reaction

Past Medical/Surgical History (continued)

Yes	No	**Have you ever had:** (If yes, please explain and note date)
☐	☐	29. Breastfeeding problems?
☐	☐	30. A gynecological surgical procedure such as:
		Cervical Conization
		LEEP Procedure
		Laser treatment
		Cryosurgery (freezing) of cervix
		Dilation/curettage (D&C)
		Cerclage
		Other: Date:
☐	☐	31. Other surgical procedures?
☐	☐	32. Hospital stay for a nonsurgical reason other than a normal delivery?
☐	☐	33. Any complications or problems from anesthesia (if yes, please explain and note date)?
☐	☐	34. Do you have a history of uterine fibroid or abnormally shaped uterus?
☐	☐	35. Evaluation or treatment for infertility?
☐	☐	36. Are you a surrogate or gestational carrier for this pregnancy?

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Yes	No	**Have you ever had:** (If yes, please explain and note date)
☐	☐	37. Does anyone in your immediate family take thyroid medication?
☐	☐	38. Is there a history of medical problems in your family that you feel might adversely affect your health or this pregnancy (such as history of blood clots in legs or lungs, diabetes, or other?)
☐	☐	39. Other problems that we have not asked you about, which you feel might be of importance to this pregnancy? If YES, what?

40. **Symptoms since last menstrual period**

Do you currently have any of the following symptoms? ☐ abdominal pain ☐ nausea and vomiting ☐ your heart racing or skipping beats ☐ pain on urination ☐ vaginal discharge or bleeding ☐ depression ☐ other:

41. Are you currently taking any medications (include prescription, over the counter, herbs)?

Genetic History

Yes	No	(If yes, please explain and note date)
☐	☐	1a. Are you interested in information about testing your blood to screen for genetic abnormalities in the baby?
☐	☐	1b. Are you interested in information about amniocentesis or chorionic villus sampling to test for genetic abnormalities in the baby?

Have you or the baby's father, or anyone in either family had: (If yes, please note your relationship to the affected person and provide details)

☐	☐	2. Brain, spinal cord, or neural tube defects (open spine, spina bifida or anencephaly)?
☐	☐	3. Congenital heart disease/defect?
☐	☐	4. Down syndrome (or other chromosome anomaly)?
☐	☐	5. Hemophilia (or other inherited problems of blood clotting)?
☐	☐	6. A muscular dystrophy (different from MS/multiple sclerosis)?
☐	☐	7. Cystic fibrosis?
☐	☐	8. Huntington disease?
☐	☐	9. Intellectual or mental disability or autism?
☐	☐	10. Other inherited genetic or chromosomal disorders?

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Yes	No	**Have you ever had:** (If yes, please explain and note date)
☐	☐	11. Are you or the father of the baby of Jewish ancestry? Have either of you been screened for Tay-Sachs disease, Canavan disease and/or familial dysautonomia? If yes, who was screened and what were the results?
☐	☐	12. Are you or the father of the baby of African-American ancestry? Have either of you been screened for sickle cell disease or trait? If yes, who was screened and what were the results?
☐	☐	13. Are you or the father of the baby of Mediterranean or Asian ancestry? Have either of you been screened for thalessemia or sickle cell disease or trait? If yes, who was screened and what were the results?

Do you (or the baby's father) have:

☐	☐	14. Insulin dependent diabetes, phenylketonuria, or any other metabolic disorder not already listed above?
☐	☐	15. A prior child with a birth defect or medical condition needing surgery at birth not listed above?
☐	☐	16. Three or more miscarriages or a prior stillbirth?
☐	☐	17. A child who died shortly after birth or during childhood?
☐	☐	18. Any other genetic risks or concerns not listed above?

Infection History

Yes	No	(If yes, please explain and note date)
☐	☐	1. We routinely test all pregnant women for infections such as Hepatitis B, HIV, and syphilis. Do you have questions about this?
☐	☐	2. Have you ever been treated for or exposed to tuberculosis?
☐	☐	3. Have you ever had gonorrhea, chlamydia, genital herpes, syphilis or HIV?
☐	☐	4. Has your partner ever had genital herpes or HIV?
☐	☐	5. Since your last period, have you had a rash over more than 50% of your body or more than one area?
☐	☐	6. Have you had any other infectious diseases?