GENERATIONS
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Aurora, CO 80012
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First OB Appointment Questionnaire

Please answer the following questions to the best of your ability. Your complete medical history will help us give you the best care possible. If you have concerns about any of these questions, please feel free to discuss them during your visit.

Name_____ ID#_____

Address_____ Phone (H)_____

_____ Phone (C)_____

Birthday (mo/day/yr)____/_____/_____Age_____Marital Status____S____M____W____D____Sep

Height_____ Pre-pregnancy Weight_____ Religion_____

Occupation (check all that apply) ☐ Homemaker

☐ Outside Work (type of work)_____

☐ Student

Education (last grade completed)_____

Father of Baby's Name_____ Age_____ Occupation_____

Medical Problems of Father of Baby?_____

Emergency Contact Person_____Relationship_____Phone_____

Age when periods started_____

How often do they come? Every_____days/months

How long do they usually last?_____days

Amount of flow?_____ Light_____ Medium_____ Heavy

First day of last period?___/_____/_____ Was that a normal period?_____Yes____ No

First day of previous period (period before that)____/_____/_____

In the past year, which type of birth control did you use?_____

Month last method of birth control was used:_____/_____/_____

Was this pregnancy planned?_____Yes_____ No

Date of positive pregnancy test:_____

Type of pregnancy test _____urine _____blood

GENETIC SCREENING QUESTIONNARE

These questions include your, baby's father, or anyone in either families medical history. Mark YES or NO.

1	Are you, the patient, 35 years or older?	NO	YES
2	Were you or the baby's father adopted?	NO	YES
3	Ancestry: Italian, Greek, Mediterranean? Asian? African American?	NO	YES
4	Neural Tube Defect (meningomyelocele, open spinal brain defect, spina bifida)?	NO	YES
5	Down Syndrome (mongolism)?	NO	YES
6	Jewish? History of Tay Sach's?	NO	YES
7	Sickle Cell Disease or Trait?	NO	YES
8	Muscular Dystrophy?	NO	YES
9	Cystic Fibrosis?	NO	YES
10	Huntington Chorea?	NO	YES
11	Mental Retardation?	NO	YES
12	If Mentally Retarded, was the person tested for Fragile X?	NO	YES
13	Other Inherited Genetic or Chromosomal Disorders?	NO	YES
14	(a) Patient or baby's father with a previous child who has a birth defect?	NO	YES
	(b) Have you had more than three miscarriages?	NO	YES
	(c) Have you had a stillbirth?	NO	YES

The following questions relate to whether or not you and the baby are at risk for infectious diseases. These questions include you and your partner. Please answer YES or NO.

History of:

Genital Herpes	NO	YES	Genital Warts	NO	YES
Chlamydia	NO	YES	HPV	NO	YES
Gonorrhea	NO	YES	Syphilis	NO	YES
Hepatits	NO	YES	Exposure to Bodily Fluids	NO	YES
Tuberculosis	NO	YES	Work in Dualysis Unit	NO	YES

PRESENT PREGNANCY

Since your last menstrual period have you had any of the following symptoms?

1	Vaginal Bleeding?	NO	YES
	If yes, when?		
2	Vaginal Discharge?	NO	YES
	Itching/Odor/Excessive Amount		
3	Vomiting?	NO	YES
	If yes, how often?		
4	Headache?	NO	YES
	If yes, how often?		

5	Abdominal Pain?	NO	YES
	If yes, when?		
6	Urinary Complaints?	NO	YES
7	Fever?	NO	YES
	If yes, how high?		
8	Rash?	NO	YES
9	Constipation?	NO	YES
	If yes, how often?		

PAST PREGNANCIES

(Includes Miscarriages and Abortions)

Delivery Date Month/Year	Length of Pregnancy	Length of Labor	Birth Weight	Type of Delivery	Anesthesia Epidural	Place of Delivery	Preterm Issues	Complications

CIRCLE YOUR PAST MEDICAL HISTORY

Diabetes	NO	YES	RH Neg Sensitive (not blood type)	NO	YES
High Blood Pressure	NO	YES	Pulmonary (TB, Asthma)	NO	YES
Heart Disease	NO	YES	Epilepsy	NO	YES
Autoimmune Disorder	NO	YES	Allergies	NO	YES
Kidney Disease / UTI	NO	YES	Breast issues	NO	YES
Neurologic / Epilepsy	NO	YES	GYN Surgery	NO	YES
Mental Illness (suicide attempts)	NO	YES	Year/Reason		
Varicose Veins / phlebitis	NO	YES	Operations/Hospitalizations	NO	YES
Thyroid problems	NO	YES	Year/Reason		
Major Accident/trauma/violence	NO	YES	Anesthesia Problems	NO	YES
History of blood transfusion	NO	YES	Abnormal Pap Smear	NO	YES
Use of Tobacco	NO	YES	Uterine Abnormality	NO	YES
# of Cigarettes/Day?			Infertility	NO	YES
Prior to Pregnancy: Now:			Medications taken since last period?		
Alcohol use since last period?	NO	YES	(including over the counter drugs)	NO	YES
Street Drugs Used (Marijuana, Cocaine,			If yes, which ones?		
Heroine, Speed or Inhalant)?	NO	YES	Caffeine since last period?	NO	YES
If yes, any since last period?			If yes, how much per day?		