



# Women's Healthcare

OF NORMAN

*Women Caring for Women*



Carol Anderson, D.O. • Leslie Ollar-Shoemake, D.O. • Lisa Waterman, D.O. •  
Daphne Lashbrook, M.D. • M. Dianne Chambers, M.D. • Allison Carter, M.D.

## Pregnancy Questionnaire

First Name: \_\_\_\_\_ Middle Initial: \_\_\_\_\_ Last Name: \_\_\_\_\_ Date: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_

### OB HISTORY:

When was the first day of your last period: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_  *Don't Know*

Were you on birth control at the time of conception?  Yes  No *If Yes, which one?* \_\_\_\_\_

How many TOTAL pregnancies have you had, including this one? \_\_\_\_\_

How many living children do you currently have? \_\_\_\_\_

What is your occupation? \_\_\_\_\_

Do you come in contact with hazardous chemicals or do any heavy lifting (>20) while on the job?  Yes  No

*If Yes, please explain:* \_\_\_\_\_

Marital Status:  Married  Single  Divorced  Widowed

Height: \_\_\_\_\_ Pre-pregnancy Weight: \_\_\_\_\_

Name of the baby's father: \_\_\_\_\_

Baby's Father's Contact Phone Number: \_\_\_\_\_

### PERSONAL MEDICAL HISTORY

This section of questions pertains to YOUR medical history. Please indicate if YOU have had any of the following:

High Blood Pressure:  Yes  No

Heart Disease:  Yes  No

Autoimmune Disorder:  Yes  No

Kidney Disease/Stone/ UTI:  Yes  No

Neurologic Disorder/Seizures:  Yes  No

Depression/Postpartum Depression:  Yes  No

History of other Mental Disorder:  Yes  No

*If Yes, what disorder and are you currently under treatment?:* \_\_\_\_\_

Hepatitis/Liver Disease:  Yes  No

Varicosities/Phlebitis:  Yes  No

Thyroid Dysfunction:  Yes  No

Sexual Abuse/Domestic Violence:  Yes  No

History of Blood Transfusion:  Yes  No

Alcohol/Drug Use:  Yes  No

Tobacco Use:  Yes  No

*If Yes, How many packs a day?* \_\_\_\_\_

Pulmonary Disorder (TB/Asthma):  Yes  No

Seasonal Allergies:  Yes  No

Drug/Latex Allergy:  Yes  No

*If Yes, please list allergy and reaction:* \_\_\_\_\_

Breast Disorder/Surgery:  Yes  No

Gynecologic Surgery:  Yes  No

Anesthetic Complications:  Yes  No

*If Yes, what complication?* \_\_\_\_\_

History of Abnormal Pap:  Yes  No

Uterine Anomaly/DES Exposure:  Yes  No

Infertility:  Yes  No

Diabetes:  Yes  No

**PERSONAL MEDICAL HISTORY (CONTINUATION)**

Please list all the medications you are currently taking, including any supplements or herbal preparations. Also include dosage and how often you are taking it.

MEDICATIONS	DOSAGE

Please list any surgeries you have had and the date:

SURGERY	DATE

Please list any previous hospitalizations and the approximate date:

REASON FOR HOSPITALIZATION	DATE

## IMMEDIATE FAMILY MEDICAL HISTORY

The following section of questions pertains to YOUR immediate family, (Parent, Grandparent and/or Siblings).

Do you have a FAMILY history of:

Heart Disease:  Yes  No

High Cholesterol:  Yes  No

High Blood Pressure:  Yes  No

Cancer:  Yes  No

If Yes, list who and what type: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Thyroid Problems:  Yes  No

Hepatitis:  Yes  No

AIDS or HIV:  Yes  No

Diabetes:  Yes  No

## GENETICS HISTORY

The following section of questions pertains to YOU, the BABY'S FATHER or EITHER OF YOUR FAMILIES.

Is there any history of:

Thalassemia  Yes  No

(Italian, Greek, Mediterranean, or Asian Descendent)

Neural Tube Defect  Yes  No

Congenital Heart Disease  Yes  No

Down Syndrome  Yes  No

Tay-Sachs Disorder  Yes  No

Sickle Cell Disease or Trait  Yes  No

Hemophilia or other Blood Disorder  Yes  No

Multiple Sclerosis  Yes  No

Cystic Fibrosis  Yes  No

Mental Retardation/Autism  Yes  No

If Yes, was the person tested for fragile X?  Yes  No

Other inherited Genetic or Chromosomal Disorder  Yes  No

Recurrent pregnancy loss or stillbirth?  Yes  No

Patient or Father of Baby had other child with birth defects not listed?  Yes  No

If you answered Yes to any of the above questions, please explain: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

## INFECTION HISTORY

Do you live with someone with TB or have you been exposed to TB?  Yes  No

Do you or your partner have history of herpes? (Oral or Genital)  Yes  No

Have you had a rash or viral illness since your last period?  Yes  No

Have you had Hepatitis B or C exposure?  Yes  No

Have you had an STD in the past year?  Yes  No

## RISKS

Have you had the following with a PREVIOUS pregnancy?

- |   |                              |                             |
|---|------------------------------|-----------------------------|
| Uterine or Cervical Malformation                      | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Suspect Pelvis (not large enough to accommodate baby) | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Rh Negative (Negative Blood Type)                     | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Anemia  | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Failure to Gain Weight (< 20 lbs.)                    | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Excessive Weight Gain (> 40 lbs.)                     | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Abnormal Fetal Presentation (Breech/Transverse Lie)   | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Post-Term Delivery (> 40 weeks)                       | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Acute Pyelonephritis                                  | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Sexually Transmitted Disease                          | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Alcohol use with Pregnancy                            | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Diabetes with Pregnancy                               | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Hypertension (High Blood Pressure)                    | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Thrombophlebitis                                      | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Herpes (Oral or Genital)                              | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Rh Sensitization                                      | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Uterine Bleeding                                      | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Polyhydramnios (High Amniotic Fluid Level)            | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Oligohydramnios (Low Amniotic Fluid Level)            | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Mild Pre-Eclampsia                                    | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Severe Pre-Eclampsia                                  | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Fetal Growth Retardation                              | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Premature Rupture of Membranes                        | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Multiple Pregnancy                                    | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Alcohol or Drug Abuse                                 | <input type="checkbox"/> Yes | <input type="checkbox"/> No |

