CAPITAL WOMEN'S CARE®
"Working Together for Women's Health"

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Initial OB Appointment Patient Questionnaire

Name _____ Date _____

DOB _____ Occupation _____

Name of Father of Baby _____ Occupation _____

Pharmacy Name _____ First day of Last Menstrual Period _____
Pharmacy Address _____

Prior Pregnancy History:

(please list ALL pregnancies, including miscarriages and abortions) ☐ **None**

Year	Type of Delivery	# of weeks	Birth Weight	Sex	Complications *(ex High BP, Diabetes, etc)*
____	_____	_____	_____	____	_____
____	_____	_____	_____	____	_____
____	_____	_____	_____	____	_____

Medical History:

Have you ever been diagnosed with: ☐ **None**

1.	Diabetes	Y	N	15.	Hepatitis / Liver Disease	Y	N
2.	High Blood Pressure	Y	N	16.	Varicosities / phlebitis	Y	N
3.	Heart Disease	Y	N	17.	Thyroid dysfunction	Y	N
4.	Autoimmune Disease	Y	N	18.	Trauma / violence	Y	N
5.	Kidney Disorder / UTI	Y	N	19.	Blood Transfusion	Y	N
6.	Neurological Disorder / Epilepsy	Y	N	20.	History of abnormal PAP	Y	N
7.	Psychiatric Disorder	Y	N	21.	Breast problems	Y	N
8.	Depression/Postpartum Depression	Y	N	22.	HIV	Y	N
9.	Blood clots / DVT	Y	N	23.	Uterine abnormality	Y	N
10.	D (Rh) sensitization	Y	N	24.	Infertility	Y	N
11.	Varicella (chicken pox)	Y	N	25.	Fertility Treatment	Y	N
12.	Pulmonary (TB, asthma)	Y	N	26.	Other relevant history	Y	N
13.	Seasonal allergies	Y	N	27.	Anesthesia Complications	Y	N
14.	Medication / latex allergies	Y	N	28.	Other	Y	N

Surgical History

(please list all surgeries and procedures, including in-office procedures) ☐ None

Year	Procedure	Year	Procedure
____	_____	____	_____
____	_____	____	_____

—> OVER

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Medications ☐ **None**

Name	Dosage	Reason for taking

Allergies (please list all medication allergies) ☐ **None**

Name of medication	Reaction

Gynecological History:

Have you ever had any STDs? Please circle ☐ **None**

HIV Gonorrhea Chlamydia Trichomonas Syphilis Herpes HPV Hepatitis B or C

Social History

Do you currently use tobacco products? Y N Type _____ # per day _____

Are there any cats in your house? Y N

Family History: (Is there any blood relative in your family diagnosed with?)

Breast cancer Y N _____

Ovarian cancer Y N _____

Colorectal cancer Y N _____

Genetic Evaluation Does anyone in your family have ? ☐ **None**

1.	Patients age 35 or older as of estimated delivery date	Y	N	Office use only
2.	Thalassemia (Greek, Italian, Mediterranean, Asian backgrounds)	Y	N	
3.	Neural Tube Defects (spina bifida, anencephaly, myelomeningocele)	Y	N	BP _____ Weight _____
4.	Congenital Heart Disease	Y	N	
5.	Down Syndrome	Y	N	BMI _____
6.	Tay Sachs Disease (Ashkenazi Jewish, Cajun, French Canadian)	Y	N	
7.	Canavan Disease (Ashkenazi Jewish)	Y	N	
8.	Familial Dysautonomia (Ashkenazi Jewish)	Y	N	
9.	Sickle Cell Trait (African or African–American)	Y	N	
10.	Hemophilia or other inherited blood disorders	Y	N	NOB labs
11.	Muscular Dystrophy	Y	N	NIPT
12.	Cystic Fibrosis	Y	N	CF/SMA
13.	Huntington's Chorea	Y	N	Hb elect
14.	Intellectual disability / developmental delay	Y	N	Toxo
15.	Other inherited genetic / chromosomal disorders	Y	N	PAP
16.	Maternal Metabolic Disorder (Type I Diabetes / PKU)	Y	N	GC/CT
17.	Patient or baby's father had a child with birth defects not listed above	Y	N	Other
18.	Recurrent pregnancy loss or stillbirth	Y	N	
19.	Medications (including supplements, vitamins, herbs, OTC drugs,	Y	N	
	illicit drugs, recreational drugs, alcohol since last period.	Y	N	_____
20.	Other	Y	N	

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