Obstetrics: New Patient Questionnaire

Please fill out as much as possible. It there is anything you are unsure of please skip it and go onto the next question. These questions will be used to help fill out your Antenatal Record.

Name:_____Date of Birth:_____Age:_____

Ethnic or Racial Background:_____

Language Spoken(s):_____

Education Level:_____Occupation:_____

Family Doctor:_____

Marital status (Circle one):
Married Single Common Law Other (please specify):_____

Height:_____ Weight:_____

The first day of your last menstrual period(MMM/DD/YYYY):_____

ContraceptiveType (condoms, birth control pill, IUD, none, etc):_____

Number of Pregnancies:_____Year(s) of pregnancies(ex: 1999):_____

Type of Delivery: (vaginal delivery/vacuum/forceps/cesarean section):_____

Number of Living Children:_____ Number of Miscarriages:_____

Year(s) of miscarriages:_____Number of Abortions:_____

Year(s) of abortions:_____Number of Living Children:_____

Previous pregnancy complications:_____

Date of last Pap test:_____Normal or Abnormal_____

Smoker: Yes or No Cigarettes per day:_____

Medications:

Drug Name:_____

Drug Allergies:

Please list ALL drug allergies:_____

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Personal Medical Problems/Conditions: (please circle if you have any of the following)

Heart Disease - High Blood Pressure - Breast Disease - Thyroid Disease - Asthma - Diabetes

Liver/Gall Bladder - Anemia - Blood Clots - Bowel Disorders - Kidney - Osteoporosis - Cancer

Other (please specify):_____

Previous Surgeries:

Year:_____Surgery:_____

Year:_____Surgery:_____

Partner Information:

Partner's Name:_____Age:_____

Partner's ethnic or Racial background:_____

Partner's Education Level:_____

Partner's Occupation:_____

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