Drs. Margolis, Alter, Wolfgram, Apgar, Krinn, King, Alam and Georgiou
GYNECOLOGICAL / OBSTETRICAL QUESTIONNAIRE

Date: ______________________________

Patient Name______________________________ DOB______________ Age________

If pregnant, name of father of baby ______________________ Religion ______________

ALLERGIES

Name of Drug	Type of reaction – rash, hives, etc.

MEDICATIONS

Name of Drug	Reason for drug

PAST OBSTETRICAL HISTORY

Full Term _______ Premature _______ Abortions _______ Miscarriages ________ Living Children ________ Ectopic _______

No.	Date	Sex	WT.	Duration Of Preg.	Duration of Labor	Type of Delivery	Anesthesia	Complications/ Name of Baby	Delivering Physicians' Name
1									
2									
3									
4									

GYNECOLOGICAL HISTORY

Last Menstrual Period__________ Age menstrual period began ______Cycle frequency _________Duration (# of days)_____

Last Pap Smear ___________ Last Mammogram ____________ Prior Contraceptive Methods____________________

Height ____________ Weight ____________ Do you do Self Breast Exam Yes No

Past Medical History

Date	

Past Surgical History

Date	PHYSICIAN	OPERATION

Family History of Disease *

Family Member		Age at Diag.

*Include any history of breast cancer, ovarian cancer and abnormal blood clots

GENETIC COUNSELING (Please circle)

1. Patient's age 35 years or older as of estimated date of delivery Yes No
2. Thalassemia (Italian. Greek, Mediterranean or Asian background) Yes No
3. Neural Tube Defects (meningomyelocele, spina bifida or anencephaly) Yes No
4. Congenital heart defect Yes No
5. Down Syndrome Yes No
6. Tay Sachs (Ashkenazi Jewish, Cajun, French Canadian) Yes No
7. Canavan Disease (Ashkenazi Jewish) Yes No
8. Familial dysautonomia (Ashkenazi Jewish) Yes No

GENETIC COUNSELING CONTINUED (Please circle)

9. Sickle Cell disease or trait (African)	Yes	No
10. Hemophilia or other blood disorders	Yes	No
11. Muscular dystrophy	Yes	No
12. Cystic fibrosis	Yes	No
13. Huntington's chorea	Yes	No
14. Mental Retardation/autism	Yes	No
15. Other inherited genetic or chromosomal disorder	Yes	No
16. Maternal metabolic disorder (e.g.: Type 1 Diabetes, PKU)	Yes	No
17. Patient or baby's father had a child with birth defects not listed above	Yes	No
18. Recurrent pregnancy loss or a stillbirth	Yes	No
19. Medications (including supplements, vitamins, herbs, or OTC drugs/ Illicit/rec. drugs/alcohol since last menstrual period	Yes	No

If yes, agent and strength/dosage:

____

____

____

MISCELLANEOUS INFORMATION:

20. Have you maintained good dental health? ____________ When was your last dental appointment? __________________

22. Will you be comfortable with a large group practice where you may see as many as seven or eight doctors during your pregnancy? ____________ Are you comfortable seeing a male physician? _________

23. Do you want the seasonal flu vaccine when it becomes available? ________________

MEDICAL HISTORY (Please Circle)

1. Diabetes Yes No
2. Hypertension Yes No
3. Heart Disease Yes No
4. Autoimmune Disorder Yes No
5. Kidney Disease/UTI Yes No
6. Neurologic/epilepsy Yes No
7. Psychiatric Yes No
8. Depression/postpartum Yes No
9. Hepatitis/liver disease Yes No
10. Varicosities/phlebitis/ blood clots Yes No
11. Thyroid dysfunction Yes No
12. Trauma/violence Yes No
13. Blood transfusions Yes No
14. Would you accept a blood transfusion? Yes No
15. D (Rh) sensitive or prior rhogam Yes No
16. Chicken pox - Varicella Yes No
17. Pulmonary (TB, Asthma) Yes No
18. Seasonal allergies Yes No
19. Drug/Latex Allergies Yes No
20. Breast Problems Yes No
21. GYN surgery Yes No
22. Operation/hospitalization Yes No
23. Anesthetic complications Yes No
24. History of abnormal PAP Yes No
25. Uterine Anomaly Yes No
26. Infertility Yes No
27. ART Treatment Yes No
28. Relevant Other History Yes No
29. Cats (as pets) Yes No
30. HPV Vaccine Yes No

    Date Completed ____________
31. Herpes – oral or genital

	Pre-pregnancy amount/packs per day	Pregnant amount/packs per day	# of years of use
Tobacco			
Alcohol			
Caffeine			
Recreational Drugs			

INFECTION HISTORY (Please Circle)

1. Live with someone with TB or exposed to TB Yes No
2. Patient or partner has history of genital herpes Yes No
3. Rash or viral illness since last menstrual period Yes No
4. Circle if history of any of the following:

HPV Gonorrhea HIV Chlamydia Syphilis Hepatitis A, B or C Herpes