OBSTETRICS PATIENT QUESTIONNAIRE

The location of your appointment is: ☐ Franciscan Physician Network - Obstetrics & Gynecology - Lafayette
3920 St Francis Way, Lafayette IN 47905

☐ Franciscan Physician Network - Obstetrics & Gynecology - Crawfordsville
1630 Lafayette Road, Suite 400, Crawfordsville IN 47933

This initial appointment will include an interview with a nurse, an examination by your physician or nurse practitioner and an interview with the financial counselor. Bring this questionnaire so the nurse can review it with you. Be sure to bring any insurance information that you have in order for the financial counselor to assist you in making financial arrangements for this pregnancy. You will also give a urine specimen and have blood drawn at this appointment.

Name:_____ Birthdate:_____

Date of first prenatal appointment:_____with Physician/Nurse Practitioner:_____

Age:_____ Occupation:_____ Marital Status:_____

Father of Baby: Name:_____ Age:_____ Occupation:_____

DATING

Date of the first day of your last menstrual period:_____

Was this a normal period?..... ☐ YES ☐ NO

Are your periods usually regular when NOT using hormonal birth control?..... ☐ YES ☐ NO

How often do your periods normally come when NOT using hormonal birth control?_____

Have you ever taken hormonal birth control(pills,shots,vaginal ring,patches,implant)?..... ☐ YES ☐ NO

If yes, when did you take your last pill, shot, etc?_____

Have you had a positive pregnancy test?..... ☐ YES ☐ NO

If yes: Date of test:_____ Where done?_____ Blood or Urine test?_____

Have you had an ultrasound during this pregnancy?..... ☐ YES ☐ NO

Weight before pregnancy:_____ Height_____

MEDICAL HISTORY

Have you had any of the following problems?

AIDS/HIV	☐ Yes ☐ No	Heart Problems	☐ Yes ☐ No	Pap smear abnormal	☐ Yes ☐ No
Asthma	☐ Yes ☐ No	Hepatitis	☐ Yes ☐ No	Date of last pap smear:	
Blood clots in Lung/Legs	☐ Yes ☐ No	High blood pressure	☐ Yes ☐ No	PKU	☐ Yes ☐ No
Blood disorder-anemia	☐ Yes ☐ No	Kidney disease	☐ Yes ☐ No	Seizures	☐ Yes ☐ No
Chickenpox or Vaccine	☐ Yes ☐ No	Liver disease	☐ Yes ☐ No	Stomach/bowel problems	☐ Yes ☐ No
Diabetes	☐ Yes ☐ No	Lung problems	☐ Yes ☐ No	Thyroid disease	☐ Yes ☐ No
Genital herpes	☐ Yes ☐ No	Migraine headaches	☐ Yes ☐ No	Transfusion	☐ Yes ☐ No
Gonorrhea	☐ Yes ☐ No	Nervous/mental disorder	☐ Yes ☐ No	Tuberculosis	☐ Yes ☐ No

Please list any type of surgery you have had and the year of the surgery:_____

_____

Please list any other hospitalizations or serious illnesses you have had (not including childbirth):_____

_____

BIRTH HISTORY Please list all of your previous pregnancies (include miscarriages and abortions):

DATE	LENGTH OF PREG	LABOR LENGTH	WT	SEX	TYPE OF DELIVERY	BABY'S NAME	HOSPITAL	M.D.	COMMENTS

PRENATAL GENETIC HISTORY

History of patient, baby's father or anyone in either family:	Your Family Yes	Your Family No	Family of baby's father Yes	Family of baby's father No	Not Applicable
Inherited anemia (Thalassema)					
Neural tube defect (Meningomyelocele, spina bifida, open spine or anecephaly)					
Congenital heart defect					
Down syndrome					
If you and baby's father are both of Jewish background, have you been tested for Tay Sachs trait?					
If you and baby's father are both of Jewish background, have you been tested for Canavan disease?					
If you and baby's father are both of Jewish background, have you been tested for Familial dysautonomia?					
If you and baby's father are both African American, have you been tested for the Sickle Cell trait?					
Hemophilia or other blood disorders					
Muscular dystrophy					
Cystic fibrosis					
Huntington's chorea					
Mental retardation/autism If yes, was the person tested for Fragile X? □ YES □ NO					
Other inherited genetic or chromosomal disorder					
Any other genetic history					

SOCIAL HISTORY

Do you smoke tobacco?..... □ YES □ NO

If yes, how much did you smoke before pregnancy?_____

how much do you smoke now?_____

As with the rest of the questionnaire, all of your answers are strictly confidential and used only to help care for your health. You do not have to answer any questions that make you uncomfortable.

How many alcoholic drinks does it take to make you feel high?....._____ drinks

Have people annoyed you by criticizing your drinking?.....□YES □ NO

Have you ever felt you ought to cut down on your drinking?.....□YES □ NO

Have you ever had a drink first thing in the morning to steady your nerves/get rid of a hangover?.□YES □ NO

Have you ever used any street drugs?..... □YES □ NO
If yes, please describe what you used, how you used it (i.e., "shoot-up", "snort", smoke, etc.)and when most recently used:_____
Has any relative, friend, or member of your household had a problem with drugs or alcohol?..... □ YES □ NO
If yes, whom?_____
Have you ever been physically abused?..... □ YES □ NO
Have you ever been forced to have sex?..... □ YES □ NO

MEDICATIONS

Has a doctor prescribed any medication for you in the past year?..... □ YES □ NO
If yes, list name of medication and when last taken:

MEDICATION	LAST TAKEN

ALLERGIES

Do you have any drug allergies?..... □ YES □ NO
If yes, list medication to which you are allergic, and the reaction you had:

MEDICATION	REACTION

HAVE YOU HAD ANY OF THE FOLLOWING PROBLEMS DURING THIS PREGNANCY?(CHECK ALL THAT APPLY)

□ Vaginal bleeding	□ Nausea or vomiting
□ Abnormal vaginal discharge	□ Constipation
□ Exposure to X-rays	

Do you have anything else you would like to tell us?