OB QUESTIONNAIRE

Patient Name: _____ D.O.B.: _____ AGE: _____

1. Have you ever had any of the following infections?

Chlamydia	Yes	No	HPV	Yes	No
Condyloma	Yes	No	Syphilis	Yes	No
Gonorrhea	Yes	No	Trichomonas	Yes	No
Hepatitis	Yes	No	Tuberculosis	Yes	No
Herpes	Yes	No			

2. Do you have any Family history of the following genetic diseases?

Canavan Disease	Yes	No
Congenital Heart Defect	Yes	No
Cystic Fibrosis	Yes	No
Down Syndrome	Yes	No
Familial Dysautonomia	Yes	No
Hemophilia or Bleeding Disorder	Yes	No
Huntington's Chorea	Yes	No
Mental Retardation/Autism	Yes	No
Muscular Dystrophy	Yes	No
Neural Tube Defect	Yes	No
Sickle Cell Disease or Trait	Yes	No
Tay-Sachs Disease	Yes	No
Thalassemina	Yes	No

3. Do you currently have High Blood Pressure? Yes No
   If yes, are you on any medication? Yes No What?_____

If you have had a previous pregnancy, please answer the following questions

4. Were you ever treated for preterm labor? Yes No
   If yes, how early did it start? _____ weeks gestation
5. Did you deliver before 36 weeks gestation? Yes No
6. Did you have High Blood Pressure? Yes No
   If yes, did you need bed rest? Yes No or Medication? Yes No
7. Was your labor induced? Yes No
   If yes, at what week? Why?
8. Did you have diabetes?
   If yes, were you on medication? Yes No What?
9. Did you have Group B Strep? Yes No Unsure
10. Did you have any bleeding problems? Yes No
11. Have you ever had any problems with the delivery of your placenta? Yes No
12. Did you deliver by cesarean section? Yes No
13. Have you ever had an ectopic pregnancy? Yes No
14. Have you ever had a still birth? Yes No
15. Have you had recurrent pregnancy losses? Yes No
16. Have you had any other pregnancy complications? Yes No