

# Comprehensive Women's Center

## NEW OB PATIENT QUESTIONNAIRE

NAME: \_\_\_\_\_ BIRTHDATE: \_\_\_\_\_

Is this your first pregnancy? ? [Yes] [No] First day of last period: \_\_\_\_\_

If this is not your first pregnancy, what number is this for you? \_\_\_\_\_

Please describe any significant information regarding any previous pregnancies:

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Do you have a history of uterine or cervical abnormalities? ? [Yes] [No]

If so, please describe: \_\_\_\_\_

Have you ever had an abnormal Pap Smear Result? [Yes] [No]

If so, when? \_\_\_\_\_ How was it treated? \_\_\_\_\_

Have you ever had a blood transfusion? [Yes] [No]

If so, please describe the circumstances: \_\_\_\_\_

Do you have any religious/moral objections to receiving a blood transfusion? [Yes] [No]

If so, please describe: \_\_\_\_\_

Have you ever experience difficulty with infertility? [Yes] [No]

If so, did you seek treatment? [Yes] [No]

What was the extent of your treatment? \_\_\_\_\_

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Are you currently taking any medications? [Yes] [No]

If yes, please list them here: \_\_\_\_\_

Do you have allergies to seafood? [Yes] [No]

Do you have drug allergies? [Yes] [No]

If yes, please list them here: \_\_\_\_\_

Job Description (include exposure to children, animals or chemicals/radiation) \_\_\_\_\_

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Please check the box to the left of each item below if you have ever experienced any of the listed medical conditions. If you check any box, please use the line next to the item to give more details about your history.

- Diabetes \_\_\_\_\_
- High blood pressure \_\_\_\_\_
- Low blood pressure \_\_\_\_\_
- Heart Disease \_\_\_\_\_
- Autoimmune disease \_\_\_\_\_
- Kidney disease \_\_\_\_\_
- Cancer \_\_\_\_\_
- Neurological disorder \_\_\_\_\_
- Psychiatric disorder (including depression) \_\_\_\_\_
- Hepatitis/liver disease \_\_\_\_\_
- Blood clots \_\_\_\_\_
- Varicose veins \_\_\_\_\_
- Thyroid dysfunction \_\_\_\_\_
- Trauma \_\_\_\_\_
- Pulmonary disease \_\_\_\_\_
- DES exposure \_\_\_\_\_
- Substance abuse \_\_\_\_\_
- Eye disorder \_\_\_\_\_
- Sexually transmitted disease \_\_\_\_\_
- Surgery/hospitalizations \_\_\_\_\_

Have you experienced any inherited diseases not listed above? [Yes] [No]

If yes, please explain \_\_\_\_\_  
\_\_\_\_\_