CEDAR PARK
WOMEN'S CENTER

Name: _____ Date of Birth: _____
Pharmacy Name: _____ Location: _____

New OB Questionnaire

Welcome to our practice and congratulations on your new pregnancy! We strive to provide thorough and personalized care for you and your family throughout your pregnancy, so please fill out the following questionnaire as completely and accurately as possible. If you have any questions, please ask a member of our staff.

Please answer the following as it pertains to you only.

When was the first day of your last period? _____
Are your periods regular (every 28-30 days)? _____
How long do your periods last? _____
Is this your first pregnancy? _____
If not, did you have any complications with your previous pregnancies? _____
_____
Do you have a primary care doctor? _____
Do you have any medical conditions? _____
Since your last period, have you taken any medications/supplements, either prescription or over-the-counter (list)? _____
Since your last period, have you had any exposure to tobacco, alcohol, or recreational drugs?
List what and how much/frequency: _____
Have you had chicken pox or the chicken pox vaccine? _____
Have you ever had a blood transfusion? _____
Would you accept a blood transfusion it you needed one? _____
Do you have a cat (cats)? _____ Are they indoor or outdoor? _____
Have you changed the litterbox since your last period? _____
Do you have contact with small children on a regular basis? _____
Have you ever been physically or sexually abused? _____
If so, do you feel safe now? _____

Please answer the following as it pertains to you, your baby's father, and any family members of you and the baby's father.

Are you of Jewish ancestry? _____
Are you of Greek, Mediterranean, or Asian ancestry? _____
Is there any history of blood or blood clotting disorders? _____
Is there any history of neural tube defects (spina bifida, anencephaly)? _____
Is there any history of congenital birth defects? _____
Is there any history of congenital heart defects? _____
Is there any history of Down Syndrome? _____
Is there any history of mental retardation? _____
Is there any history of chromosomal disorders? _____
Is there any history of metabolic disorders or cystic fibrosis? _____
Do you have any history of sexually transmitted infection (HIV, Herpes, Syphilis, Hepatitis, Chlamydia, Gonorrhea)? _____
Have you had any exposure to tuberculosis? _____