

Place sticker here

The Emory Clinic Obstetric (Prenatal) Patient Questionnaire

Name: _____

Age: _____ Marital status: S M W D Sep

Occupation: Homemaker Student Outside employment : _____

Address: _____
Street City State Zip

Education (last grade completed): _____ Phone: Hm _____ Wk _____

Name of baby's father: _____ Age _____ Relationship _____ Phone _____

Number of pregnancies:

Total ____, Full term ____, Premature ____, Abortion ____, Miscarriage ____, Tubal ____, Twin ____, Living ____

Menstruation:

Date your last menstrual cycle began: _____

Was this cycle on time and did it last the expected number of days? _____

If you recall, when was the start of the previous cycle? _____

Usual cycle length in days (start to start): _____

Last time birth control medication used: _____

Age at first menses _____

Mo/Year	Weeks	Labor time (hrs)	Birth weight	Sex of baby	Vaginal, C-section, vacuum or forceps	Anesthesia: natural, IV, epidural, general	Hospital	Child OK (X if no)	Premature labor (X if yes)

History of:	Yes-you	Yes-close family	No	History of:	Yes-you	Yes-close family	No
Diabetes				Rh-negative blood			
Hypertension				Tuberculosis or contact with			
Heart disease				Asthma			
Autoimmune disorder				Medication or latex allergy			
Kidney disease/bladder infections				OB/GYN surgery			
Neurologic or epilepsy disorder				Other surgery			
Nervous and mental disorder				Anesthesia problems			
Hepatitis/liver disease				Abnormal pap			
Phlebitis				Abnormal uterus shape			
Thyroid problems				Mother took diethylstilbestrol (DES)			
Major accidents/domestic violence				Difficulty getting pregnant			
Blood transfusion				Chicken pox or vaccine			
Smoker							
Alcohol use							
Illicit Drugs				Please turn to other side			

You or partner, close family or your child	Yes	No	You or partner, close family or your child	Yes	No
Over 35 years old at delivery			Mental retardation		
Italian, Greek, Oriental or Mediterranean			Other inherited condition		
Open spine, abnormal brain			Diabetes		
Heart defect at birth			Phenylketonuria (PKU)		
Down syndrome (Mongolism)			Birth defects not listed above		
Jewish			Four or more miscarriages		
Sickle cell disease or trait			Stillbirth		
Hemophilia			Hearing loss from birth		
Muscular dystrophy			SIDS (sudden infant death syndrome)		
Cystic fibrosis					
Huntington chorea					

Infection History:

	Yes	No		Yes	No
Have you had hepatitis B or been vaccinated for it?			Rash or virus since becoming pregnant?		
Have you been exposed to TB?			History of STD (e.g., gonorrhea, chlamydia, HPV, syphilis)?		
Do you or does your partner have or carry herpes?			Partner using IV drugs?		

Medications since last menstrual period:

Prenatal vitamins: Yes No

Medication	Dates taken	Strength	Times per day	Purpose

Do you have a cat? Y N

Other information you believe is important for us to know: _____

Signature

Date