Obstetrical Health History Questionnaire:

FIRST PHYSICIANS GROUP
of Sarasota Memorial Health Care System

Name_____ Date of birth_____

Address_____

Local phone number_____ Alternative phone number_____

Special Communication Needs:		
Language preference:		
If 'yes' to any of the questions below, how can we assist?		
Visual impairment	☐ Yes ☐ No	
Hearing impairment	☐ Yes ☐ No	
Speech impairment	☐ Yes ☐ No	
Cognitive impairment	☐ Yes ☐ No	
Sensory impairment	☐ Yes ☐ No	
Are there any religious or cultural factors that you would like us to take into account when planning your healthcare?		

Marital Status ☐ Single ☐ Married/Life Partner *Years Together* _____ ☐ Divorced ☐ Widowed

Parental Health History		
	Patient/Mother	**Husband or Partner/Father**
Country of Birth:		
Race:		
Religion		
Education:		
Occupation:		
Significant Family Disease:		

Mother only Pre-pregnancy Weight:_____ Months Attempting Pregnancy: _____

Father only Age: _____ Height: _____ Weight: _____

Personal Health History

Please check past(P) or current(C) problems or conditions

P☐ C☐ Kidney Disease/UTI	P☐ C☐ DES Exposure	P☐ C☐ Abdominal Pain
P☐ C☐ Heart Disease	P☐ C☐ Thyroid Dysfunction	P☐ C☐ Urinary Complaints
P☐ C☐ Mitral Valve Prolapse	P☐ C☐ Phlebitis/Varicose Veins	P☐ C☐ German Measles
P☐ C☐ Hypertension	P☐ C☐ Blood Transfusion	P☐ C☐ Other Virus: _____
P☐ C☐ Rheumatic Fever	P☐ C☐ RH Sensitivity	P☐ C☐ Radiation Specify:_____
P☐ C☐ Asthma	P☐ C☐ Vomiting	
P☐ C☐ Tuberculosis	P☐ C☐ Constipation	P☐ C☐ Accidents
P☐ C☐ Hepatitis/Liver Disease	P☐ C☐ Headache	P☐ C☐ Chemical/Toxin Exposure
P☐ C☐ Abnormal Uterus	P☐ C☐ Rash	P☐ C☐ Other: _____

Menstruation: First Day of Last Period: _____ Length: _____ Occurs Every _____ Days Normal? ☐ Yes ☐ No

Obstetrical Health History

Total Pregnancies:	Full Term:	Premature:	Living:
Spontaneous Miscarriages:	Ectopic:	Multi-births:	Elective Abortions:

Date of Delivery	Place of Delivery	Weeks Gestation	Gender	Hours in Labor	Weight	Type of Delivery	Anesthesia	Comments Mother	Complications Baby

List Surgeries:

Social History:

Live here year round? ☐ Yes ☐ No If no, Part time location: _____

Tobacco use: ☐ Never ☐ Quit (when)_____ ☐ Current smoker: Packs/day, how many years_____

Do you have pets? ☐ Yes ☐ No Type(s): _____

Alcohol use: ☐ No ☐ Yes If yes how many drinks/how often_____

Illicit Drug use (including marijuana, cocaine, steroids): ☐ Never ☐ Past ☐ Current
Describe:_____

Additional Health History

Please answer the following questions:	**YES**	**NO**
Are you of Asian, Pacific Island or Alaskan Eskimo Decent?	☐	☐
Were you born in Haiti or Sub-Saharan Africa?	☐	☐
Do you have a history of acute or chronic liver disease?	☐	☐
Do you work in or receive treatment in a hemodialysis unit?	☐	☐
Do you have a history of rejection as a blood donor?	☐	☐
Have you or your partner had a blood transfusion?	☐	☐
Do you have occupational exposure to blood in a medicodental setting?	☐	☐
Do you have household contact with a hepatitis carrier or hemodialysis patient?	☐	☐
In the last five years, have you had a sexual relationship with a partner that may have had a sexually transmitted disease?	☐	☐
Have you had more than one sexual partner in the past ten years?	☐	☐
Have you or your partner used injectable “street drugs”?	☐	☐
Do you have a bisexual partner?	☐	☐
Do you have any parents or siblings with diabetes?	☐	☐
Have you had a child with a birth weight of 9lbs or more?	☐	☐
Do you have a history of Glycosuria (sugar in urine)?	☐	☐
Do you or the baby’s father have a family history of any of the following (please check any that apply) ☐ Down’s Syndrome ☐ A chromosomal abnormality ☐ Neural Tube Defect (i.e., spina bifida, anencephaly, or hydrocephalus) ☐ Hemophilia ☐ Muscular Dystrophy ☐ Cystic Fibrosis ☐ Huntington’s Chorea	☐	☐
Have you or the baby’s father had a child born dead or alive with a birth defect not mentioned above?	☐	☐
Do you or the baby’s father have any close relatives with mental retardation? If yes, relation _____	☐	☐
Are you and the baby’s father first cousins or more closely related?	☐	☐
Have you or the baby’s father had a chromosomal study? If yes, who and what were the results? _____	☐	☐
Are you or the baby’s father of Jewish ancestry? If yes, have either of you been screened for Tay-Sachs disease ☐ Yes ☐ No If yes, what were the results? _____	☐	☐

Additional Health History (cont'd)		
Are you or the baby's father of African ancestry? If yes, have either of you been screened for the sickle cell trait? ☐ Yes ☐ No If yes, what were the results? _____	☐	☐
Are you or the baby's father of Italian, Greek, or Mediterranean ancestry? If yes, have either of you been screened for B-Thalassemia? ☐ Yes ☐ No If yes, what were the results? _____	☐	☐
Are you of the baby's father of Philippine or Southeast Asian ancestry? If yes, have either of you been screened for the A-Thalassemia? ☐ Yes ☐ No If yes, what were the results? _____	☐	☐
Excluding Iron and Vitamins, have you taken any medications or recreational drugs since being pregnant and/or since your last menstrual period?	☐	☐
If yes, please list the medications and the time taken during pregnancy ☐ _____ ☐ _____ ☐ _____ ☐ _____		

Allergies: Please list any allergies to medications , foods, or materials (including latex)	
Name	Symptom/Reaction

Additional Providers:	
Primary Care Provider	**Other**
Name: _____	Name: _____
Phone: _____ Last Seen:_____	Phone: _____ Last Seen: _____

Patient/Guardian Signature:_____ Date:_____