OBSTETRICAL AND GYNECOLOGICAL CARE

1110 Oak Ridge Drive • Eau Claire, WI 54701

PRENATAL QUESTIONNAIRE

NAME _____

AGE _____ RELIGION _____ RACE _____ EDUCATION _____

FATHER OF INFANT NAME (optional) _____

AGE _____ RELIGION _____ RACE _____ EDUCATION _____

How long have you been together? _____ (optional)

MENSTRUAL HISTORY: No. of days of your average cycle _____ How much do the cycles vary _____

How long do your periods last? _____ The date of your last period _____ Was it regular? ☐ Yes ☐ No

What contraception were you using _____ When did you stop _____

Did you do a pregnancy test? ☐ Yes ☐ No Date it was positive _____

PREGNANCY HISTORY: How many times have you been pregnant _____ How many full term _____ Born Alive _____

Premature _____ Stillborn _____ Ended before 5 months _____ Miscarriages _____ More than 1 infant _____

Have you had:	Yes	No		Yes	No
Nausea	☐	☐	Abdominal Pain	☐	☐
Vomiting	☐	☐	Vaginal Bleeding	☐	☐
Constipation	☐	☐	Vaginal Discharge	☐	☐
Infection	☐	☐	Other	☐	☐

What medications have you taken since last period _____ Allergies _____

Current medications _____

YOUR HEALTH HISTORY:

In the past have you had:	Yes	No		Yes	No
Thyroid Problems	☐	☐	Do you get cold sores	☐	☐
Diabetes	☐	☐	Does your partner get cold sores	☐	☐
High Blood Pressure/Mitral Valve	☐	☐	Viral Infection	☐	☐
A Blood Vessel Problem	☐	☐	An Inherited Disease	☐	☐
Jaundice/Transfusion	☐	☐	Syphilis, Gonorrhea, Herpes	☐	☐
Heart Problems/Rheumatic Fever	☐	☐	Chlamydia, (genital warts)		
Sickle Cell Anemia	☐	☐	or other STD's (specify) _____		
Kidney/Bladder Problem	☐	☐	Chicken Pox	☐	☐
Accident	☐	☐	Surgery	☐	☐
Was your last Pap Smear normal?	☐	☐	Do you use alcohol/tobacco/drugs (specify) _____	☐	☐

Date of last Pap Smear _____ Any abnormal paps? _____ If so, when? _____

What was your pre-pregnancy weight _____ current height _____ When was the last time you had a tetanus? _____

FAMILY HISTORY:

Has anyone in your family had:	Yes	No		Yes	No
Diabetes	☐	☐	An Inherited Disease	☐	☐
High Blood Pressure/Heart Disease	☐	☐	A Deformity At Birth	☐	☐
Cancer	☐	☐	Multiple Births (twins, triplets, etc.) _____	☐	☐

Is the father of the infant healthy? If no, explain _____

Please complete the following obstetrical history for each pregnancy.

OBSTETRICAL HISTORY								**BABY**			
NO.	YEAR	PLACE	WEEKS GEST	HOUR LABOR	TYPE DELIVERY	WT. GAIN	COMPLICATIONS OF PREGNANCY, LABOR, DELIVERY, PUERPERIUM	WEIGHT	CONDITION AT BIRTH	SEX	NAME
1											
2											
3											
4											
5											
6											
7											