New Patient Questionnaire

Please help us provide the best healthcare for you by completing this short form.
Your answers will become part of your medical record.

Name_____

Date of Birth _____ Age_____ Height _____

Current Medications / Supplements ☐ None

Please list **ALL** medications or supplements you take:

Name	Dosage	Frequency	Rx or Over the Counter

Medical Illnesses / Major Health Problems:

☐ None

Condition	Dates
☐Current ☐Past	
☐Current ☐Past	
☐Current ☐Past	
☐Current ☐Past	
☐Current ☐Past	

Do you have medicine, nut, seafood, iodine or latex allergies? (please circle which one)

☐No Allergies

Other Allergies:	Reaction

Gynecologic History ☐ Hysterectomy (no need to answer questions re: period)

Date of LMP (first day of last period) _____ Are your periods regular? ☐No ☐Yes

Average number of days between menses (ex: 28 days) _____ How many days of flow _____

Average blood loss: ☐Light ☐Normal ☐Heavy Cramps?: ☐No ☐Mild ☐Moderate ☐ Severe

Age at the time of first menstruation _____

When was your last pap smear? _____

Ever had an abnormal pap smear? ☐ No ☐Yes (treatment?) _____

Date of last mammogram _____,DEXA bone scan_____,colonoscopy_____

Current birth control method _____

Are you currently sexually active? ☐No ☐Yes

Does your sexual partner have any illnesses or STD's? ☐No ☐Yes (explain)_____

_____

Any history of sexually transmitted illness? ☐No ☐Yes (explain) _____

_____

Have you completed the Gardasil (HPV) vaccine series? ☐No ☐Yes

Any questions or concerns about your sexuality or sexual relations? _____

_____

See Reverse

Pregnancy History

Have you ever been pregnant? ☐No ☐Yes (please list below)

Date of delivery, type of delivery, fetal gender, fetal weight, baby's name, any complications?

#1 _____

#2 _____

#3 _____

#4 _____

Surgical History ☐None

Date of Surgery Type of Surgery

_____

_____

_____

Have you ever been hospitalized for any reason other than childbirth or surgery? ☐No ☐Yes

When_____Reason_____

Family History (if positive history, please list age at diagnosis)	***Siblings*** Brothers, Sisters	***Mother's side*** Mom, Grandmother, Grandfather, Aunt, Uncle	***Father's side*** Dad, Grandmother, Grandfather, Aunt, Uncle
Ovarian Cancer			
Breast Cancer			
Colon Cancer			
Uterine Cancer			
Heart Disease			
Blood Clots			
Osteoporosis			
Diabetes			
Other			

Mother: ☐Alive, year of birth:_____ ☐Deceased ☐Unknown

Father: ☐Alive, year of birth:_____ ☐Deceased ☐Unknown

Are you of Ashkenazi Jewish decent with a family history of any of the above cancers? ☐No ☐Yes

Social History

Marital status? ☐Single ☐Married ☐Separated ☐Divorced ☐Widowed Occupation: _____

Smoke? ☐No ☐Yes (how much) _____ Do you drink alcohol? ☐No ☐Yes (how much) _____

Recreational drug use? ☐No ☐Yes (explain) _____

Any concerns in your personal relationships? ☐No ☐Yes (explain) _____

Do you feel safe in your current relationship? ☐Yes ☐No (explain) _____

Are there any other issues you would like to share with us?_____

_____

Are you fasting today? ☐No ☐Yes When did you last eat? _____

Thank You

*Office Use Only *	BP	WT

06/15/2017

Name _____ Age _____ Date _____

Bellegrove OB-GYN Prenatal Questionnaire

Welcome to Bellegrove OB-GYN. We look forward to providing your pregnancy care. In order to help us provide the best care for you, we need to learn more about your medical and social history. Please complete the following information. Feel free to ask us for clarification if you do not understand the nature of any of the questions.

Ethnicity _____ Planned Pregnancy **No Yes** Partner supportive **No Yes**

Marital Status **Single Married** Height _____ Pre-Pregnancy weight _____

Baby's Father's Name (FOB) _____ FOB Birth Date _____

FOB Occupation _____ FOB Ethnicity _____

Pregnancies

Total number of pregnancies _____
Number of full term preg. _____
Number of premature preg. _____
Number of terminations _____
Number of miscarriages _____
Number of ectopic preg. _____
Number of multiples _____
Number of living children _____

Menses

1st day of last period (LMP)? _____
Are your periods regular? _____
How frequent are your periods? _____
Age at first period? _____
Was your last period normal? _____
Taking BCP at conception? _____
Date of 1st positive preg. test? _____
Type of test (circle one) **Blood Urine**

Pregnancy Number	**1**	**2**
Date of delivery/Miscarriage		
# Weeks of pregnancy		
Hours of labor		
Weight of baby		
Sex of baby (circle one)	Male Female	Male Female
Type of delivery (circle one)	C-Section Vaginal Forceps Vacuum	C-Section Vaginal Forceps Vacuum
Anesthesia (circle one)	Epidural Spinal General None	Epidural Spinal General None
Hospital / Location		
Obstetrician		
Complications		
Name of baby		

Pregnancy Number	**3**	**4**
Date of delivery/Miscarriage		
# Weeks of pregnancy		
Hours of labor		
Weight of baby		
Sex of baby (circle one)	Male Female	Male Female
Type of delivery (circle one)	C-Section Vaginal Forceps Vacuum	C-Section Vaginal Forceps Vacuum
Anesthesia (circle one)	Epidural Spinal General None	Epidural Spinal General None
Hospital / Location		
Obstetrician		
Complications		
Name of baby		

☐ Check if additional pregnancies charted on reverse page

FORM A

Pregnancy Number	**5**	**6**
Date of delivery/Miscarriage		
# Weeks of pregnancy		
Hours of labor		
Weight of baby		
Sex of baby (circle one)	Male Female	Male Female
Type of delivery (circle one)	C-Section Vaginal Forceps Vacuum	C-Section Vaginal Forceps Vacuum
Anesthesia (circle one)	Epidural Spinal General None	Epidural Spinal General None
Hospital / Location		
Obstetrician		
Complications		
Name of baby		

Pregnancy Number	**7**	**8**
Date of delivery/Miscarriage		
# Weeks of pregnancy		
Hours of labor		
Weight of baby		
Sex of baby (circle one)	Male Female	Male Female
Type of delivery (circle one)	C-Section Vaginal Forceps Vacuum	C-Section Vaginal Forceps Vacuum
Anesthesia (circle one)	Epidural Spinal General None	Epidural Spinal General None
Hospital / Location		
Obstetrician		
Complications		
Name of baby		

Pregnancy Number	**9**	**10**
Date of delivery/Miscarriage		
# Weeks of pregnancy		
Hours of labor		
Weight of baby		
Sex of baby (circle one)	Male Female	Male Female
Type of delivery (circle one)	C-Section Vaginal Forceps Vacuum	C-Section Vaginal Forceps Vacuum
Anesthesia (circle one)	Epidural Spinal General None	Epidural Spinal General None
Hospital / Location		
Obstetrician		
Complications		
Name of baby		

Medications (please include name, dosage and frequency of medication) □ **None**

1. ☐ Prenatal Vitamins
2. _____
3. _____
4. _____
5. _____
6. _____

Allergies (please include allergy and reaction) □ **No known allergies**

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____

Medical History (please circle no or yes; if yes, please explain)

Heart disease	□ No	□ Yes	_____
High blood pressure	□ No	□ Yes	_____
Respiratory problems	□ No	□ Yes	_____
Neurologic problems	□ No	□ Yes	_____
Diabetes	□ No	□ Yes	_____
Autoimmune disorder	□ No	□ Yes	_____
Kidney disease/UTI	□ No	□ Yes	_____
Depression/Anxiety	□ No	□ Yes	_____
Hepatitis	□ No	□ Yes	_____
Pulmonary embolism	□ No	□ Yes	_____
Blood clots in legs	□ No	□ Yes	_____
Thyroid problems	□ No	□ Yes	_____
Blood transfusion	□ No	□ Yes	_____
RH sensitized	□ No	□ Yes	_____
Drug/Latex allergy	□ No	□ Yes	_____
Breast problems	□ No	□ Yes	_____
Operations	□ No	□ Yes	_____
Hospitalizations	□ No	□ Yes	_____
Anesthetic problems	□ No	□ Yes	_____
Uterine abnormalities	□ No	□ Yes	_____
Date of last pap smear	□ No	□ Yes	_____
Result of last pap	□ No	□ Yes	_____
History of abnormal pap	□ No	□ Yes	_____
Other	□ No	□ Yes	_____

Family History (please circle no or yes; if yes, who and note if a personal history or of baby's father)

Cardiac defects	□ No	□ Yes	_____
Birth defects	□ No	□ Yes	_____
Familial disorders	□ No	□ Yes	_____
Diabetes	□ No	□ Yes	_____
Hypertension	□ No	□ Yes	_____

Social History (please circle no or yes; if yes, please explain)

Tobacco use	□ No	□ Yes	_____
Alcohol use	□ No	□ Yes	_____
Recreational drug use	□ No	□ Yes	_____
Domestic violence	□ No	□ Yes	_____
Occupation			_____

HISTORY

Genetics Screening/Teratology Counseling (please circle no or yes; if yes, please explain)

Do you or your partner have a personal or family history of any of the following?

Down syndrome	☐ No	☐ Yes_____
Cystic Fibrosis	☐ No	☐ Yes_____
Thalassemia (if yes please circle one)	☐ No	☐ Yes_____
		Italian Greek Mediterranean Asian Other
Neural Tube Defect	☐ No	☐ Yes_____
Congenital Heart Defect	☐ No	☐ Yes_____
Ashkenazi Jewish Ancestry	☐ No	☐ Yes_____
Tay-Sachs	☐ No	☐ Yes_____
Canavan Disease	☐ No	☐ Yes_____
Sickle cell disease or trait	☐ No	☐ Yes_____
Hemophilia or other blood disorders	☐ No	☐ Yes_____
Muscular Dystrophy	☐ No	☐ Yes_____
Mental Retardation/Autism	☐ No	☐ Yes_____
If yes, was person tested for Frag X	☐ No	☐ Yes_____
Other inherited genetic disorders	☐ No	☐ Yes_____
Patient or baby's father had a child with birth defects not listed?	☐ No	☐ Yes_____
Recurrent pregnancy loss/stillborn	☐ No	☐ Yes_____
Medications/Illicit/Recreational drugs/alcohol since LMP	☐ No	☐ Yes_____
If yes, Agent(s) and strength/dosage		_____
Any other genetic concerns?	☐ No	☐ Yes_____

Infection History (please check no or yes; if yes, please explain)

Lives with someone with TB or exposed to TB	☐ No	☐ Yes_____
Patient or partner with genital herpes	☐ No	☐ Yes_____
Rash or viral illness since last menstrual period	☐ No	☐ Yes_____
History of STD, GC, Chlamydia, HPV, Syphilis	☐ No	☐ Yes_____
At risk for chicken pox (as no history or vaccine)	☐ No	☐ Yes_____

Other _____

Have you or your sexual partner traveled to an area known to have Zika virus within the last 12 weeks?
http://wwwnc.cdc.gov/travel/page/zika-travel-information
(If Yes, please note location and travel dates) No ☐ Yes_____

_____

GENETICS