Name: _____ DOB: _____ DoD: _____

OB Questionnaire:

1. Who is your Primary Care Clinic and Provider? _____
2. What is the best phone number to contact you? _____
3. Can I leave a detailed message on your voicemail? Yes or No
4. Do you have access to the MHS Genesis Patient Portal? Yes or No
5. What is the first day of your last period? _____ Are they regular? Y or N
6. Have you ever had any surgeries to include dental surgery? Y or N Please list dates and procedures:

   _____

   _____
7. Have you had any pelvic trauma to include falls, accidents, or previous birth trauma to your hips or pelvic area? Y or N
8. Have you ever had an abnormal pap smear requiring a colposcopy or LEEP procedure? Y or N
9. Any allergies to medications? _____
10. Are you currently taking medications to include over the counter or prenatal vitamins?

    _____

    _____
11. Have you stopped any medications since becoming pregnant? Y or N
12. What is your pre-pregnancy height and weight? _____
13. Do you plan to move out of the area, PCS or ETS during this pregnancy? Y or N
14. Are there any genetic disorders in your or your partners immediate family to include each other?

    _____
15. How many pregnancies to include this pregnancy have you had? _____

If this is your first pregnancy, Skip to question 20.

If this is NOT your first pregnancy, please continue.

Pregnancy	gestational age	Birth Weight	Type of delivery	complications	Baby's gender	duration of labor
ex. 1	38wks	7lbs 4oz	vaginal	pre-eclampsia	male	12 hours
0						
1						
2						
3						
4						
5						
6						
7						

16. Please give any details for any preterm deliveries (before 37 weeks) listed above.
    _____
    _____
17. Please give details of any complications listed above. (Diabetes, hypertension, pre-eclampsia).
    _____
    _____
18. Please list any post-partum issues you have had with other deliveries (post-partum hemorrhage, shoulder dystocia etc.)
    _____
    _____
19. Did any of your babies have to go to the NICU or require special care after delivery?
    _____
    _____
20. Do you have any concerns currently about your pregnancy?
    _____
    _____
    _____

Office staff only:
POC testing result: positive / negative Date: ____/___/___ Technician initials _____

Name: _____ DOB: _____ DoD: _____