NEW LIFE CLINIC
OBSTETRICAL QUESTIONNAIRE

Name: _____ DOB:_____ Age:_____

Who was/is your previous primary care provider(s)? _____

What is your preferred pharmacy? _____

CURRENT MEDICATIONS (Please bring in your medications if available)

Name of Medication	Strength of Medication	Dosing Instructions

ALLERGIES

☐ No Known Allergies ☐ Medication Allergies ☐ Environmental/Seasonal ☐ Latex

Allergy	Reaction

PAST MEDICAL HISTORY (Check all that apply)

☐ Acid Reflux/GERD
☐ Anemia
☐ Autoimmune disease
☐ Asthma/lung disease
☐ Bleeding disorders
☐ Congenital Anomaly
☐ Depression
☐ Cancer (please specify) _____
☐ Diabetes
☐ Endocrine Disorder
☐ Gastrointestinal Disorders
☐ General Anesthesia Problems
☐ Heart Disease
☐ Hepatitis/Liver Disease
☐ Female pelvic infections
☐ HIV/AIDS
☐ Hypertension
☐ Infertility
☐ Kidney Disease
☐ Migraine Headaches
☐ Muscle or Joint Disease
☐ Neurological Disease
☐ Pap smear abnormality
☐ Pelvic surgery/fracture
☐ Psychiatric Disease
☐ Seizures/Epilepsy
☐ Thyroid Disorder
☐ Transfusion
☐ Tuberculosis
☐ Uterine Anomaly
☐ Vascular Disease

PAST SURGICAL HISTORY

Date of Surgery (Operations)	Type of Surgery (Operations)

FAMILY HISTORY (Check all that apply)

☐ Anemia	☐ Canavan Disease	☐ Congenital Heart Defect	☐ MentalDisease
☐ Autism	☐ Cancer	☐ Cystic Fibrosis	☐ Muscular Dystrophy
☐ Clotting Disorder	☐ Chromosomal abnormality	☐ Diabetes	☐ Neural Tube Defect
☐ Phenylketonuria (PKU)	☐ Psychiatric Disorder	☐ Sickle Cell Disease	☐ Seizure Disorders
☐ Thalassemia	☐ Problems with anesthesia	☐ Huntington's Disease	☐ Tay-Sachs Disease

☐ Other (Please list) _____

THIS PREGNANCY

Date of your last period: _____ How sure are you? ☐ Unsure ☐ Somewhat sure ☐ Sure ☐ Absolutely
How many days is your cycle? (Please circle) <=25 26 27 28 29 >=30.
How many days is your period? _____

Was this a planned pregnancy? ☐ Yes ☐ No; If no, were you on birth control? ☐ Yes (type)_____ ☐ No

Do you feel you are having problems with this pregnancy (please explain)? _____
_____
_____
_____

List all the medications you have taken since becoming pregnant. _____
_____

Are you taking a daily Prenatal Vitamin (PNV)? ☐ Yes ☐ No (We recommend a PNV with 600 mcg of Folic Acid)

PREGNANCY HISTORY (If this is your first pregnancy, congratulations, you may skip this section.)

Pregnancy Number	Weeks of Gestation*	Date of Delivery**	Sex and Weight	Provider Name	Location	Hours of Labor	Type of Delivery	Complications
1								
2								
3								
4								
5								
6								
7								
8								
9								
10								

*Weeks of gestation is from 6 to 44 weeks (40 weeks is Full Term) **List approximate date if miscarriage.

SOCIAL HISTORY

Personal History

Marital Status ☐ Single ☐ Significant other ☐ Married ☐ Divorced ☐ Widowed
Name of Significant Other/Spouse (if applicable): _____

Children: ☐ Yes ☐ No Number of Sons _____ Number of Daughters _____
Name(s) and Age(s) of Child(ren): _____

Living Situation: ☐ Live Alone ☐ With Significant Other/Spouse ☐ With Children/Family Members ☐ Other
Occupation: _____
Hobbies/Interests: _____

Tobacco

Have you ever smoked? ☐ Yes ☐ No If yes, what do (did) you smoke? _____

Are you still smoking? ☐ Yes ☐ No

If no: How many years ago did you quit? _____ For how many years did you smoke? _____ How many packs/day did you smoke? _____

If yes: How many years have you smoked? _____ How many packs/day do you smoke? _____
Have you ever tried to quit? ☐ Yes ☐ No

Alcohol

Do you drink alcohol including beer, wine, or other alcohol? ☐ Yes ☐ No
If yes, please specify frequency:

☐ Daily ☐ Almost Daily (4-6 times per week) ☐ 1-3 times per week ☐ Less than once per week

Illicit Drugs

Do you use any drugs or prescription medications not prescribed to you? ☐ Yes ☐ No
(including marijuana, cocaine, amphetamines, pain or anxiety medications, etc.)
If yes, please specify type of drug and frequency of use: _____

Diet/Activity

Are you on any special diet? ☐ Yes ☐ No
If yes, how would you describe your diet? (South Beach, Atkins, low calorie, renal, diabetic, low sodium, low fat, high protein, etc.) _____

Do you currently participate in any regular activity to improve or maintain your physical fitness (either on your own or in a formal class)? ☐ Yes ☐ No If yes, please describe: _____
_____

Health Planning

Do you have Advanced Directives in place? ☐ Yes ☐ No

☐ Living Will ☐ Durable Power of Attorney ☐ Health Care Proxy ☐ Advanced Directives

HEALTH MAINTENANCE

Please provide the dates and results of the following immunizations, examinations, and tests to the best of your ability. If you have not had one of these services indicate N/A (not applicable).

Last Tetanus Booster	☐ Within the past 10 yrs.	☐ More than 10 yrs. Ago		☐ Unknown
Flu vaccine this season?	☐ Yes ☐ No			
Last PAP Smear	Date: _____	☐ Normal	☐ Abnormal	☐ Unknown
Last Mammogram	Date: _____	☐ Normal	☐ Abnormal	☐ Unknown

CONCERNS

Please list any concerns regarding the health of this child in the space provided.

_____
_____
_____
_____
_____
_____
_____
_____

Patient Name (printed): _____

Signature _____ Date: _____

We would like to thank you for taking the time to complete this form. Doing so provides us with the information necessary to make the most out of each and every healthcare visit.