WOMEN'S MEDICAL
associates
2520 S. Telshor Blvd, Las Cruces, NM 88011 – (575) 522-9793

OBSTETRICAL QUESTIONNAIRE

Name: _____ Date of Birth: _____ Today's Date: _____

The following questions and answers assist in identifying health care needs and evaluating and providing for specific health care services as indicated.

GENETIC HISTORY

1. Will you be 35 years or older when the baby is due? YES or NO
2. Have you, the baby's father or nay one in either of your families ever had any of the following disorders?
   - Down syndrome YES or NO
   - Autism YES or NO
   - Neural tube defect, i.e. spina bifida (meningomyelocele or open spine anencephaly) YES or NO
   - Hemophilia YES or NO
   - Cystic fibrosis YES or NO
   - Sickle Cell YES or NO
   - Fragile X syndrome YES or NO

   If yes, indicate the relationship of the affected person to you or the baby's father: _____
   _____
3. Do you or the baby's father have any birth defects? YES or NO
   If yes, who has the defect and what is it? _____
4. In any previous relationship, have you or the baby's father had a child, born dead or alive with a birth defect not listed in #2? YES or NO
   If yes, what was the defect and who had it? _____
5. Do you or the baby's father have any close relatives with mental retardation? YES or NO
   If yes, indicate the relationship of the affected person on you or the baby's father: _____
   _____
6. Do you, or the baby's father, or a close relative in either family have a birth defect, any familial disorder, or a chromosomal abnormality not listed above? YES or NO
7. In any previous relationship, have you or the baby's father had a stillborn or three or more first trimester spontaneous pregnancy loss? YES or NO
   If yes, had either of you had a chromosomal study? YES or NO
   If yes, indicate who and the results: _____
8. If you or the baby's father are of Jewish ancestry, have with of you been screened for Tay-Sach's disease? YES or NO
   If yes, indicate who and the results: _____
9. If you or the baby's father are of Italian, Greek, or Mediterranean background have either of you been tested for B-Thalassemia? YES or NO
   If yes, indicate who and the results: _____
10. If you or the baby's father are black have either of you been tested for sickle cell traits? YES or NO
    If yes, indicate who and the results: _____

11. If you or the baby's father are of Philippine or Southeast Asian ancestry, have either of you been tested for A-Thalassemia? YES or NO
    If yes, indicate who and the results: _____
12. Please list ALL mediations you are currently taking. Including vitamins, supplements both over the counter and prescription since becoming pregnant or since your last menstrual period:

_____
_____
_____

PAST PREGNANCIES/MISCARRIAGES/ABORTIONS

How many times have you been pregnant? (Including current pregnancy and any miscarriage or abortions) _____
Please list ALL pregnancies below:

Date of Birth	Doctor/Hospital	Weeks pregnant	Vaginal or C-section	Birth Weight	Sex (M or F)	Complications

1. Have any of your pregnancies ended in stillborn? YES or NO
2. Were any of your pregnancies complicated by premature contractions or Premature delivery? YES or NO
3. Have any of your deliveries required forceps or vacuum extraction? YES or NO
4. Have any of your deliveries required an episiotomy? YES or NO
5. Have you had gestational diabetes, hypertension or preeclampsia with any of your pregnancies? YES or NO
6. Are you interested in permanent sterilization? YES or NO

MENSTRUAL HISTORY

1. When was the first day of your last menstrual period? _____
2. Was it on time? _____ Was it a normal flow? _____
3. How many days from the first day of your period to the first day of your next period? _____
4. What was the last method of birth control used? _____
5. When did you discontinue using birth control? _____
6. Have you had a pregnancy test? YES NO Date: _____ Place: _____
7. Was this a planned or unplanned pregnancy? (circle one) Planned or Unplanned

CURRENT PREGNANCY PROBLEMS

1. Nausea / Vomiting YES NO How often? _____
2. Vaginal bleeding / spotting YES NO How often? _____
3. Cramps / Contractions YES NO
4. Had any x-rays or ultrasounds YES NO Reason for treatment? _____
5. Fever or rash YES NO
6. Have you been ill since becoming pregnant? YES NO

YOUR MEDICAL HISTORY

1. Diabetes YES NO
2. Epilepsy / Seizures YES NO
3. Asthma YES NO
4. Heart disease or murmur YES NO
5. Diagnosed depression/anxiety YES NO
6. Urinary tract infections YES NO
7. Kidney or bladder problems YES NO
8. Blood transfusion YES NO
9. Hemorrhage YES NO
10. Blood clots YES NO
11. Anemia YES NO
12. High blood pressure YES NO
13. Chicken pox YES NO
14. Rubella or radiation exposure YES NO
15. Headaches or Migraines YES NO
16. Last pap smear _____
17. Abnormal pap smear YES NO
18. Surgeries, broken bones or concussions YES NO
19. Did your mother take hormones while pregnant YES NO
20. Anesthesia complications YES NO
21. Sexually transmitted disease YES NO
22. Lupus, arthritis, muscle or joint disease YES NO
23. Ulcer or stomach problems YES NO
24. Tuberculosis YES NO
25. Female or gynecologic problems YES NO
26. Allergies to food or medications YES NO
27. Have you travelled outside the country in the last year YES NO

If yes to any questions above, please leave details:

_____

_____

_____

SOCIAL HISTORY

1. Do you smoke? YES NO If so, how many cigarettes a day? _____
2. Have you ever smoked? YES NO If so, when did you quit? _____
3. Anyone in your household smoke? YES NO
4. Have you ever used drugs? YES NO
   If yes, include current and past use, what kind and when? _____
5. Do you have any tattoos? YES NO
6. What is the highest level of education completed? _____
7. What is your current occupation? _____ How many hours do you work a week? _____
8. What is your ethnic background? _____
9. Do you have a religious preference? _____
10. What is your marital status? (circle one)
    Married Single Separated Divorced Partnership
11. Is the father of the baby involved with the pregnancy? YES NO
12. Father of the baby's name: _____ Age: _____ Race: _____
    Occupation: _____ Phone #: _____ (in case of emergency, optional)
13. Are you now or have you ever been physically or verbally abused? YES NO
14. Have you received counseling for the abuse? YES NO
15. Do you exercise? YES NO If so, how often? _____
16. Do you drink caffeinated beverages? YES NO If so, how many cups a day? _____

Updated 2/22/19 –SL

FAMILY HISTORY

The following questions concerns your father, mother, sisters, brothers, aunts, uncles, first cousins, and grandparents.
If yes to any questions, please provide as much details as possible.

Patient family history

Diabetes:	
Epilepsy:	
Heart Disease:	
High blood pressure:	
Kidney or bladder disease:	
Tuberculosis:	
Twins or Triplets:	
Autoimmune disorders:	
Anesthesia complications:	
Cancer:	
Female Cancers (i.e. Breast, ovarian or uterine)	
Psychiatric disorders	
Other:	

Father of baby's health history: _____

Father of baby's family history:

Diabetes:	
Epilepsy:	
Heart Disease:	
High blood pressure:	
Kidney or bladder disease:	
Tuberculosis:	
Twins or Triplets:	
Autoimmune disorders:	
Anesthesia complications:	
Cancer:	
Female Cancers (i.e. Breast, ovarian or uterine)	
Psychiatric disorders	
Other:	

PROVIDER PREFRENCE

We believe in specializing your overall obstetrical care and experience.

If medically appropriate, you have the choice of the **type** of provider—doctor or midwife.

Please select your preference or if you have questions or would like more information, please indicate below. If there is a specific doctor or midwife, please circle the name below.

Please remember, due to the call schedule, there may be a possibility that you would encounter one of our other providers when you deliver.

☐ Doctor: Callaghan, Ratleff, Tabibi, Wellington

☐ Midwife: Herrera, Matherly, Falkner

☐ Both Services ☐ All Providers ☐ Would like more information

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