unitedregional
physician group

Obstetric History Questionnaire

Patient Name:_____ DOB: _____

What was the first day of your last menstrual period? _____

Are your periods regular? _____

What is your due date if known? _____ What is your blood type? _____

Are there any problems with your current pregnancy? Or current health problems?

_____

What pharmacy do you use? _____

Prior Pregnancies

Live Births: _____ Miscarriages: _____Abortions:_____

Fill in information in table below for each pregnancy (whether the child is living or deceased). Please start with your first one. Also please list under delivery type if forceps or a vacuum were used.

Year	Weeks	Labor Length	Birth wt.	sex	Type of Delivery (Vaginal or Cesarean Section)	Living?

Please list below any complications or comments regarding prior pregnancies listed above:

_____

Who do you plan on using for a pediatrician? _____

Who is your family doctor? _____ _____

Do you plan on breast feeding this child? _____

Do you plan on having an epidural? _____

Do you plan on permanent sterilization after having your baby? _____

Would you accept blood products if needed? Yes No

What is your occupation? _____

Are you and the father of this baby blood related? (Circle one) Yes No

What is the name of the father of the baby? _____

What is the age of the father of the baby? _____

Is the father of this baby your sexual partner? (Circle one) Yes No

How would you describe the ancestry of the father of this baby? (Circle all that apply)

Caucasian French Canadian Asian African Mediterranean

Hispanic Native American Asian-East Indian Other -Southeast Asian

Hispanic Ashkenazi Jewish Middle Eastern Unknown

Please list all of your current medications or provide a medication list to the nurse.

Name of medication	Dose	How many times each day?	For what condition?

Are you allergic to any medications? If **yes**, please list reaction.

Medication allergy	Allergic reaction

Have you used any street drug since becoming pregnant? **YES** **NO**

Social History Information

Are you adopted? **Yes** **No**

Tobacco Use: Current ____ Former ____ Never____ Type_____Vaping_____

Alcohol Use: Current ____ Former ____ Never ____ Type _____

Drug use: Current ____ Former ____ Never ____ Type _____

Caffeine use: Current ____ Former _____ Never ____ Type _____

Have you had any exposure to any of the following?

□ Sauna □ Cat Litter □ X-rays □ Hot Tub □ Chemicals □ Fever/ Infections/ Rash □ Electric Blanket

Have you had any illnesses since becoming pregnant? _____

When was your last pap smear?_____

Have you ever had an abnormal pap? If So, When_____

If you have had an abnormal pap, have you ever had any of the following? (Please include date)

COLPOSCOPY_____ **LEEP**_____ **CRYO THERAPY**_____

When was your last mammogram?_____

Depression Screening

In the past **2 weeks**, have you been bothered by any of the following problems? Check answer

1. **Little interest or pleasure in doing things?**

   ____ Not at all ___ Several Days ___More than half the days ___Nearly every day

2. **Feeling down, depressed or hopeless?**

   ____ Not at all ___ Several Days ___More than half the days ___Nearly every day

How hard is it for you to pay for the basic needs like food, housing, medical care or heating?

Not hard at all Not very hard Somewhat hard Hard Very hard

Within the past 12 months, have you ran out of food before you had money to buy more?

YES NO

Within the past 12 months has lack of transportation kept you from medical appointments or from getting your medications?

YES NO

Within the past 12 months has lack of transportation kept you from work, meetings or getting things you needed?

YES NO

Have you had any surgeries? Please list below

Surgery	Age	Year

Intimate Partner Violence Screen

Within the past year, have you been afraid of your partner or ex-partner?

YES NO REFUSE TO ANSWER

Within the last year, have you been hit, kicked, slapped or otherwise physically harmed by your partner or ex-partner?

YES NO REFUSE TO ANSWER

Within the last year, have you been raped or forced to have any sexual activity by anyone?

YES NO REFUSE TO ANSWER

If this is your first pregnancy, would you be interested in special nurse visits to your home to help with education and support with your current pregnancy? **YES NO N/A**

Do you, the father of the baby, or any close relatives have any of the following?

If yes, please specify which relative. **Person affected**

Thalassemia MCV < 80	**YES**	**NO**	_____
Spina Bifida or Anencephaly	**YES**	**NO**	_____
Congenital Heart Defects	**YES**	**NO**	_____
Down Syndrome	**YES**	**NO**	_____
Sickle Cell Disease or Trait	**YES**	**NO**	_____
Hemophilia or bleeding problems	**YES**	**NO**	_____
Muscular Dystrophy (type_____)	**YES**	**NO**	_____
Cystic Fibrosis	**YES**	**NO**	_____
Other inherited genetic disorders	**YES**	**NO**	_____
Mental Retardation/Autism/ Learning Disorder	**YES**	**NO**	_____
Recurrent Pregnancy Loss	**YES**	**NO**	_____
Blindness or Deafness	**YES**	**NO**	_____
Dwarfism	**YES**	**NO**	_____
Kidney Disorder	**YES**	**NO**	_____
Blood Clots or Stroke	**YES**	**NO**	_____
Pt or father of the baby has a child with a birth defect?	**YES**	**NO**	_____

Anything else that seems to run in the family?

_____

_____

_____

Family Medical History

	Mother	Father	Sister	Brother	Maternal Grand Mother	Maternal Grand Father	Paternal Grand Mother	Paternal Grand Father
Alcoholism								
Anxiety								
Arthritis								
Asthma								
Cancer								
Diabetes								
Heart Disease								
High Cholesterol								
High Blood Pressure								
Kidney Disease								
Osteoporosis								
Seizures								
Stroke								
Thyroid Disease								

Do you have any of the following?

Unexplained Fever	Yes	No	Unsure
Vision problems	Yes	No	Unsure
Sinus Problems	Yes	No	Unsure
Acid reflux	Yes	No	Unsure
Close Contact with person with tuberculosis?	Yes	No	Unsure
Asthma	Yes	No	Unsure
Heart murmur	Yes	No	Unsure
Mitral Valve	Yes	No	Unsure
Other heart problems	Yes	No	Unsure
High blood pressure in pregnancy	Yes	No	Unsure
Chronic high blood pressure	Yes	No	Unsure
Other high blood pressure	Yes	No	Unsure
Recurrent UTI / Kidney stones	Yes	No	Unsure
Severe nausea and vomiting in pregnancy	Yes	No	Unsure
Hepatitis A	Yes	No	Unsure
Hepatitis B	Yes	No	Unsure
Hepatitis C	Yes	No	Unsure
HIV / AIDS	Yes	No	Unsure
Kidney Stones	Yes	No	Unsure
Menstrual problems	Yes	No	Unsure
Infertility	Yes	No	Unsure
Recurrent pregnancy loss	Yes	No	Unsure
Vaginal infections	Yes	No	Unsure
Herpes	Yes	No	Unsure
Gonorrhea	Yes	No	Unsure
Chlamydia	Yes	No	Unsure
Syphilis	Yes	No	Unsure
Genital Warts	Yes	No	Unsure
Abnormal pap	Yes	No	Unsure
Diabetes	Yes	No	Unsure
Thyroid problems	Yes	No	Unsure
Seizures	Yes	No	Unsure
Migraines/headaches	Yes	No	Unsure
Lupus	Yes	No	Unsure
History of blood transfusion	Yes	No	Unsure
Blood clots	Yes	No	Unsure
RH sensitizing	Yes	No	Unsure
Depression	Yes	No	Unsure
Anxiety	Yes	No	Unsure

MYRIAD myRisk® Hereditary Cancer

Cancer Family History Questionnaire

Personal Information

Patient Name	Date of Birth	Healthcare Provider	Today's Date

Instructions: Your personal and family history of cancer is important to provide you with the best care possible. Your provider will use this information as a screening tool for cancers that run in families. Please complete the chart below based upon your personal and family history of cancer. Leave blank what you do not know.
The following relatives should be considered: Parents, siblings, half-siblings, children, grandparents, grandchildren, aunts, uncles, nieces, and nephews on both sides of the family.

Do you have a personal history of:	Yes (Y) or No (N)?	Which cancer?	Age at diagnosis?
Breast, ovarian, or pancreatic cancer at any age	☐ Y ☐ N		
Colorectal or uterine cancer at 64 or younger	☐ Y ☐ N		

Do you have a family history of:	Yes (Y) or No (N)?	Which relative?	Maternal (M) or Paternal (P) side of the family?	Age at diagnosis?
Breast cancer at 49 or younger	☐ Y ☐ N		☐ M ☐ P	
Two breast cancers (bilateral) in one relative at any age	☐ Y ☐ N		☐ M ☐ P	
Three breast cancers in relatives on the same side of the family at any age	☐ Y ☐ N		☐ M ☐ P	
Ovarian cancer at any age	☐ Y ☐ N		☐ M ☐ P	
Pancreatic cancer at any age	☐ Y ☐ N		☐ M ☐ P	
Male breast cancer at any age	☐ Y ☐ N		☐ M ☐ P	
Metastatic prostate cancer at any age	☐ Y ☐ N		☐ M ☐ P	
Colon cancer at 49 or younger	☐ Y ☐ N		☐ M ☐ P	
Uterine cancer at 49 or younger	☐ Y ☐ N		☐ M ☐ P	
Ashkenazi Jewish ancestry with breast cancer at any age	☐ Y ☐ N		☐ M ☐ P	
Do you have a family history of other cancers?	☐ Y ☐ N	List them here:		
Have you or anyone in your family had genetic testing for hereditary cancer?	☐ Y ☐ N	Who?	What gene(s)?	What was the result?

Your provider will use the following information to determine if you should consider carrier screening.

Do you plan to become pregnant in the next year?	☐ Y ☐ N	Do you have Ashkenazi Jewish ancestry?	☐ Y ☐ N

What age were you when you started your first period? _____ Age at the time of your first birth? ____

If you are menopausal, what age did you go through menopause? _____ Have you had any breast biopsies? Y / N

If you are menopausal, have you used any hormone replacement therapy? YES/NO How many years? ____

How many daughters do you have? ____ Sisters?_____Maternal Aunts?_____Paternal Aunts?_____