OFFICE USE ONLY: DR _____

WT _____ HT _____

BP_____ EDC_____

Lakeside Doctors
Gynecology & Obstetrics

Obstetrical Form
Please use **BLACK INK only**

Patient History Questionnaire

1. Name_____ Date _____

1. Reason for this visit: _____

2. Referring Physician: _____ **3.** How did you hear about us? _____

4. Preferred phone number: _____

5. Pharmacy and Address: _____ Pharmacy Phone: _____

6. Primary Care Physician: _____ Address: _____ Phone: _____

7. Partner's Name: _____ or ☐ NONE

8. Partner's Phone Number ( ) _____ **9.** Partner's Age _____

Current Medications (Please list all medications, vitamins and supplements.)

Medication	Dose	Frequency

Are you allergic to any medications? ☐ No ☐ Yes

List Medicine and Reaction: _____

_____

Vaccine History

TDAP ☐ NO ☐ YES If yes, Date of Vaccination: _____

COVID ☐ NO ☐ YES If yes, Date of Vaccination: _____

Pneumonia ☐ NO ☐ YES If yes, Date of Vaccination: _____

Gardasil (HPV) ☐ NO ☐ YES If yes, Date of Vaccination: _____

Shingles ☐ NO ☐ YES If yes, Date of Vaccination: _____

Flu ☐ NO ☐ YES If yes, Date of Vaccination: _____

Gynecological/Menstrual History

1. Age of first period_____ **2.** Do you have cramps? ☐ NO ☐ YES

3. Flow: ☐ Light ☐ Moderate ☐ Heavy **4.** Duration of flow: _____

5. If your menstrual periods are regular; periods start every _____ days

6. If your menstrual periods are irregular; periods start every _____ to_____ days (e.g., 12 to 60)

7. First day of last menstrual period: _____ (m/d/year) **8.** Date of pregnancy test:_____ ☐ Blood ☐ Urine

9. Were you on birth control when you became pregnant? _____ **10.** Was this pregnancy planed? ☐ NO ☐ YES

Pap Smear/ Mammogram

1. Date of last pap smear: _____ **2.** Have you had treatment for abnormal smears? ☐ NO ☐ YES

3. Have you had any of the following for abnormal pap:

: Cryotherapy? If so, when? _____ Laser? If so, when? _____

Cone Biopsy? If so, when? _____ Loop Excision (LEEP)? If so, when? _____

4. Have you had a Mammogram? ☐ NO ☐ YES Date: _____ Result? _____Location: _____

Pregnancy History (All pregnancies) **Have never been pregnant** ☐

OBSTETRICAL HISTORY INCLUDING MISCARRIAGES, ABORTIONS & ECTOPIC (TUBAL) PREGNANCIES

# of pregnancies:	**# of full term births:**	**# of pre-term births:**	**# of pregnancy losses:**	**# of living children:**	**# of induced abortions:**

Date of Delivery	Place of Delivery	Duration Pregnancy	Hours of Delivery	Vaginal Delivery or C-Section	Complications Mother/Infant	Child's Sex	Birth Weight	Present Health

Family History

Illness	**Relation**	**Maternal**	**Paternal**	**Illness**	**Relation**	**Maternal**	**Paternal**
1. AIDS (HIV)	_____	☐	☐	**11.** High Blood Pressure	_____	☐	☐
2. Anemia/ Blood Disorder	_____	☐	☐	**12.** High Cholesterol	_____	☐	☐
3. Anesthesia Complications	_____	☐	☐	**13.** Kidney Disease	_____	☐	☐
4. Birth Defects	_____	☐	☐	**14.** Lung Cancer	_____	☐	☐
5. Breast Cancer	_____	☐	☐	**15.** Osteoporosis	_____	☐	☐
6. Colon Cancer	_____	☐	☐	**16.** Ovarian Cancer	_____	☐	☐
7. Diabetes	_____	☐	☐	**17.** Rheumatoid Arthritis/ Lupus	_____	☐	☐
8. Deep Vein Thrombosis	_____	☐	☐	**18.** Stroke	_____	☐	☐
9. Endometrial Cancer	_____	☐	☐	**19.** Uterine Cancer	_____	☐	☐
10. Heart Disease	_____	☐	☐	**20.** Other _____			

Social History

1. Marital Status: (Circle One) Single Married Long Term Relationship Divorced Widowed

2. Preferred Pronouns: (Circle One) She/Her He/Him They/Them

3. Do You Smoke: ☐ No ☐ Yes _____packs/day ☐ Former Smoker _____ packs/day _____ years

4. Occupation: _____ **5.** Religion: _____

6. Stress Level: (circle one) ☐ Low ☐ Medium ☐ High **7.** Diet: ☐ Regular ☐ Vegetarian ☐ Other: _____

8. Exercise: Type: _____ How Often:_____

9. Sexual Orientation: ☐ Heterosexual ☐ Homosexual ☐ Bisexual **10.** Do you have sex with: ☐ Men ☐ Women ☐ Both

11. Sexually Active? ☐ NO ☐ YES **12.** Any new sexual partners in the last year? ☐ NO ☐ YES

13. Is sexual intercourse painful? ☐ NO ☐ YES **14.** Current Birth Control Method: _____

15. Do You Drink Alcohol: ☐ NO ☐ YES How Many Drinks/Week? _____ Have you had any since your pregnancy test? ☐ NO ☐ YES

16. Caffeine Intake: (circle one) None Occasional Moderate Heavy

17. Do You Use Illicit Drugs: ☐ NO ☐ YES Type _____ Last Used _____

18. Number of Hours of Sleep Each Night: _____hrs.

Past Obstetrical/Gynecological Surgeries

Check any that apply: or ☐ NONE

SURGERY	YEAR	SURGERY	YEAR
☐ Cesarean Section	_____	☐ L Cyst(s) Removed Ovarian	_____
☐ D&C	_____	☐ R Cyst(s) Removed Ovarian	_____
☐ Hysteroscopy	_____	☐ L Ovary Removed	_____
☐ Infertility Surgery	_____	☐ R Ovary Removed	_____
☐ Laparoscopy	_____	☐ Vaginal or Bladder Repair	_____
☐ Myomectomy	_____	☐ Other _____	

Past Surgical History (Not OB/GYN)/ Hospitalizations

Please List All Surgeries: **OR ☐ NONE**

SURGERIES/ HOSPITALIZATIONS	YEAR
_____	_____
_____	_____
_____	_____

Other Symptoms ☐ NONE

Have you had recent?

☐ Breast Tenderness	☐ Cramping	☐ Fatigue	☐ Nausea
☐ Vaginal Bleeding	☐ Vomiting	☐ Weight Gain	☐ Weight Loss
☐ Other _____			

Past Medical History ☐ NONE

☐ AIDS (HIV)
☐ Anemia/Blood Disorder
☐ Anesthesia Complications
☐ Anxiety Disorder
☐ Arthritis/Lupus
☐ Asthma
☐ Birth Defects or Inherited Disease
☐ Blood Transfusion
☐ Breast Cancer
☐ Breast Problem: Type _____
☐ Cancer: Type _____
☐ Chlamydia/Gonorrhea
☐ Depression
☐ Diabetes: Type _____
☐ Diet Controlled ☐ Pill Controlled ☐ Insulin Controlled
☐ Deep Vein Thrombosis
☐ Endometriosis
☐ Female/Sexual Problems
☐ Headaches/Migraines
☐ Heart Conditions
☐ Hepatitis: Type _____
☐ Herpes (HSV)
☐ High Blood Pressure
☐ High Cholesterol
☐ Infertility
☐ Kidney or Bladder Problems
☐ Liver Disease
☐ Lung Disease: Type _____
☐ Ovarian Cancer
☐ Psychiatric Illness: Type _____
☐ Rheumatic Fever
☐ Seasonal Allergies
☐ Sexual Abuse/Domestic Violence
☐ Stomach, Bowel or Gall Bladder Problems
☐ Syphilis
☐ Thyroid Problems
☐ Tuberculosis
☐ Varicosities (Varicose Veins)
☐ Other _____

Are you or will you be 35 years of age or older at delivery? ☐ NO ☐ YES

Have you traveled in the past 3 months? If so, where? _____

Have you had: ☐ Exposure to Tuberculosis ☐ Rash or viral illness since LMP ☐ Partner history of Genital Herpes

Have you or the baby's father or anyone in your families ever had any of the following:

☐ Down Syndrome? If yes, who? _____
☐ Other Chromosomal Abnormality? If yes, who? _____
☐ Neural Tube Defect (Spina Bifida, Anencephaly)? If yes, who? _____
☐ Hemophilia or Other Coagulation Abnormality? If yes, who? _____
☐ Muscular Dystrophy? If yes, who? _____
☐ Cystic Fibrosis? If yes, who? _____
☐ If you or the baby's biological father are of Jewish ancestry, have either of you been screened for Tay-Sachs Disease?
☐ Father Result _____
☐ Mother Result _____
☐ If you or the baby's biological father are of African ancestry, have either of you been screened for Sickle Cell Trait?
☐ Father Result _____
☐ Mother Result _____
☐ If you or the baby's biological father are of Italian, Greek or Mediterranean background, have either of you been tested for B-thalessemia?
☐ Father Result _____
☐ Mother Result _____
☐ If you or the baby's biological father are of Philippine or Southeast Asian ancestry, have either of you been tested for A-thalessemia?
☐ Father Result _____
☐ Mother Result _____

1) Please select the answer that comes closest to how you have felt in the **last 7 days**:

- **a.** I have been able to laugh and see the funny side of things:
  - **i.** As much as I always could
  - **ii.** Not quite so much now
  - **iii.** Definitely not so much now
  - **iv.** Not at all
- **b.** I have looked forward with enjoyment to things:
  - **i.** As much as I ever did
  - **ii.** Rather less than I used to
  - **iii.** Definitely less than I used to
  - **iv.** Hardly at all
- **c.** I have blamed myself unnecessarily when things went wrong:
  - **i.** No, never
  - **ii.** Not very often
  - **iii.** Yes, some of the time
  - **iv.** Yes, most of the time
- **d.** I have been anxious or worried for no good reason:
  - **i.** No, not at all
  - **ii.** Hardly ever
  - **iii.** Yes, sometimes
  - **iv.** Yes, very often
- **e.** I have felt scared or panicky for no very good reason
  - **i.** No, not at all
  - **ii.** No, not much
  - **iii.** Yes, sometimes
  - **iv.** Yes, quite a lot
- **f.** Things have been getting on top of me:
  - **i.** No, I have been coping as well as ever
  - **ii.** No, most of the time I have coped quite well
  - **iii.** Yes, sometimes I haven't been coping as well as usual
  - **iv.** Yes, most of the time I haven't been able to cope at all
- **g.** I have been so unhappy that I have had difficulty sleeping
  - **i.** No, not at all
  - **ii.** Not very often
  - **iii.** Yes, sometimes
  - **iv.** Yes, most of the time
- **h.** I have felt sad or miserable
  - **i.** No, Not at all
  - **ii.** Not very often
  - **iii.** Yes, sometimes
  - **iv.** Yes, most of the time
- **i.** I have been so unhappy that I have been crying
  - **i.** No, never
  - **ii.** Only occasionally
  - **iii.** Yes, quite often
  - **iv.** Yes, most of the time
- **j.** The thought of harming myself has occurred to me
  - **i.** Never
  - **ii.** Hardly ever
  - **iii.** Sometimes
  - **iv.** Yes, quite often