The Women's Medical Center

LCMC Health

OB questionnaire (Please print)

Name_____ Date_____

1. When was the first day of your last period?_____/_____/_____

2. Is this your first pregnancy? O Yes O No If yes, go to #3.
   How many times have you been pregnant (including your current pregnancy)?_____
   How many children do you have?_____
   Did you experience any of the following problems during or after your previous pregnancies?

   O Blood transfusion
   O Cesarean section
   O Forceps/vacuum delivery
   O Gestational (pregnancy) diabetes
   - O Diet controlled
   - O Pills by mouth
   - O Insulin

   O Ectopic pregnancy
   O Elevated blood pressure or seizures
   O Growth restriction/small baby
   O Incompetent cervix/cerclage/need for progesterone injections
   O Large baby >/+ 9 lbs
   O Molar pregnancy
   O Placental abruptio/abnormal bleeding/hemorrhage
   O Postpartum depression
   O Preterm delivery before 37 weeks
   O Shoulder dystocia/broken clavicle/arm injury during delivery
   O Stillbirth

   Any other complication that we should know about?_____

3. Have you seen a doctor or been to the ER during this pregnancy? O Yes O No
   If yes, which hospital?_____ Date(s) seen_____
4. Are you allergic to any medications? Please list_____ Reaction_____
5. Check any medical problems you have.

   O Alcohol abuse
   O Asthma
   O Blood clots in your legs/lungs
   O Depression
   O Drug abuse
   O Genital herpes
   O Hepatitis
   O High blood pressure/hypertension
   O HIV
   O Kidney disease
   O Seizure/epilepsy
   O Sickle cell trait/disease
   O Stroke
   O Syphilis
   O Thyroid problems

6. List any medications that you take, include medications that you should be taking or stopped recently due to pregnancy_____

7. Do you or the father of your baby or your families have any of the following?

   O Cystic Fibrosis
   O Down Syndrome
   O Heart defects
   O Mental retardation
   O Sickle Cell Disease/trait
   O Spina Bifida

   Please explain or list any birth defects not listed_____
8. List any surgeries that you have had_____
9. Do you have any religious objection to a blood transfusion? O Yes O No
10. How many doses of the COVID-19 Vaccine have you received?_____
11. Which pharmacy would you like to use?_____