New OB Patient Questionnaire

NAME: ____________________ PHONE: ______________ DATE: ____________

DOB: ____________________ EDD:__________________ SSN:______________

1. Do you have medical insurance? ☐ YES ☐ NO

   Provider: ____
2. Do you have secondary coverage? ☐ YES ☐ NO

   Provider:____
3. Previous or current physician: ______________________________________
4. First day of last menstrual period: ___________________________________
5. How many times have you been pregnant? _________ Deliveries? __________
6. How did you deliver your last child? ☐ Cesarean ☐ Vaginal
7. Did you have prenatal care during your previous pregnancy? ☐ YES ☐ NO
8. Did you have any complications during previous pregnancies? ☐ YES ☐ NO
9. Have you ever delivered pre-term? If so, how many weeks? ___________________
10. Do you currently experience or have a history of:
    a. Diabetes: ☐ YES ☐ NO
    b. High blood pressure or pre-eclampsia: ☐ YES ☐ NO
    c. DVT or blood clots: ☐ YES ☐ NO
    d. Kidney problems: ☐ YES ☐ NO
    e. Anxiety: ☐ YES ☐ NO
    f. Drinking: ☐ YES ☐ NO
    g. Smoking: ☐ YES ☐ NO

11. Are you currently on any medications, including over-the-counter? If so, please list:

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12. Have you been to the ER during this pregnancy? If so:

When? ___________________________ Why? __________________________________

PHYSICIANS APPROVAL: ☐ YES ☐ NO