Atrius Health
Part of Optum®

For Clinician Use
PAS LABEL
Form Version: 8.14.23

Initial OB Health Questionnaire

If you have MyHealth & answered the on-line questionnaire, you DO NOT NEED to complete this paper form.

*This information helps your obstetric care team in developing a care plan during your pregnancy. It addresses health and social issues. **Please answer all questions as thoroughly as possible and bring the completed questionnaire to your initial obstetric appointment**. Your clinician will review this form with you & address any concerns you have regarding your pregnancy. You are welcome to bring your partner or support person with you to obstetric appointments.*

PATIENT

Name: ____

Telephone #: Cell: ____________ (H) _______________

(W):_____________________ Marital Status: ________

Work: *Choose one*
__Part-Time or Temporary work
__Full Time work
__Otherwise Unemployed-not seeking work (e.g., student, retired, unpaid primary care giver): ___________
If working, Occupation: ___________________________

If working, Employer: _____________________________

PARTNER/SUPPORT PERSON

Name: ____

Address: _______________________________________

Telephone # (H): ____________ (W) _______________

Occupation: _____________________________________

Employer: _______________________________________

EMERGENCY CONTACT

Name: ____

Telephone #: _____________________________________

Relationship to Patient: ___________________________

ALLERGIES & MEDICATIONS:

Are you allergic to any **MEDICATIONS**? ☐ **None** If yes, please specify medications and reactions below:

____

Do you have any **OTHER ALLERGIES**? ☐ **None**
If yes, please specify allergies and reactions below:

____

Are you **currently taking any medications**? ☐ **None** If yes, please specify below:

____
Medication *Dose* *Frequency*

____
Medication *Dose* *Frequency*

____
Medication *Dose* *Frequency*

MENSTRUAL HISTORY:

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

Did you get your period when you expected to and was the length and flow normal for you? ☐ yes ☐ no

If not, when was your last normal period? ___________ How often do you menstruate?_________

Type of birth control last used: _____________________ Date last used: ___________

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EDC by LMP:

GENETIC BACKGROUND: *Your race/heritage may affect your baby's risk for inherited disorders. Please check all that apply.*

Your race/heritage: ___ African American/Black ___ Asian ____ Caucasian ___ Eastern-European Jewish ____Cajun ___ French-Canadian ___Haitian Creole ___ Hispanic ___ Mediterranean ___Native American ___ Other (please specify) ___________________ ____Don't know

Father of baby race/heritage: ___ African American/Black ___ Asian ____ Caucasian ___ Eastern-European Jewish ____Cajun ___ French-Canadian ___Haitian Creole ___ Hispanic ___ Mediterranean ___Native American ___ Other (please specify) ____________________ ____Don't know

Age of baby's father: _______________

Please indicate if the following applies to you or your family – leave blank if no. Online just asks in general

GENETICS	Self	Your family member (Who?)	Biological father of baby	Father of baby family member	EXPLANATION
History of child with birth defect					
Family member with birth defect					
Neural tube defect, spina bifida, anencephaly					
Intellectual disability or autism (diagnosis?)					
Carrier of genetic disease					
Chromosomal problems-please specify					
Cystic fibrosis					
G6PD deficiency					
Hemophilia					
Inborn error of metabolism (special diet as a child?)					
Muscular dystrophy					
Polycystic kidneys					
Sickle cell anemia/sickle cell trait					
Spinal Muscular Atrophy (SMA)					
Tay Sachs Disease					
History of child with heart abnormalitiy					
History of child with kidney/bladder abnormaltiy					
History of child with cleft lip or other facial abnormality					
History of child with club foot or other limb abnormality					
History of child with genital abnormality					
None of the above					

REVIEW OF SYSTEMS*:* Check if you *currently* have *problems* with:

- ☐ fatigue
- ☐ weight loss
- ☐ weight gain
- ☐ enlarged glands or lumps
- ☐ environmental allergies
- ☐ heat or cold intolerance
- ☐ excess hair growth or loss
- ☐ skin problem: _____
- ☐ moles
- ☐ chest pain
- ☐ persistent cough
- ☐ shortness of breath
- ☐ wheezing
- ☐ difficulty breathing
- ☐ indigestion, nausea or vomiting
- ☐ abdominal pain or bloating
- ☐ constipation
- ☐ diarrhea
- ☐ painful urination
- ☐ abnormal vaginal discharge
- ☐ muscle or joint pain
- ☐ back pain
- ☐ headaches
- ☐ fainting/dizziness/balance problems
- ☐ anxiety
- ☐ depression
- ☐ memory loss
- ☐ trouble sleeping
- ☐ varicose veins
- ☐ breast pain
- ☐ breast lump
- ☐ Other_________________

MEDICAL HISTORY –MEDICAL HISTORY:

CONDITION-*have you had in past or now?*	**X** if yes	**Comments**
Blood, Circulatory		
Anemia (iron, B12, folic acid deficiency)		
Varicose veins or phlebitis		
Blood clots in legs or lungs		
Rh sensitization		
History of transfusions		
Problems with blood clotting or easy bruising		
High blood pressure (including pre-eclampsia)		
Endocrine		
High blood sugar (diabetes)		
Gland problems (thyroid, adrenal, pituitary)		
Respiratory		
Asthma (childhood/adult)		
Sleep Apnea		

CONDITION – *have you had in past or now?*	X if yes	Comments
Cardiac		
Heart murmur		
Rheumatic fever		
Mitral valve prolapse		
Heart attack		
Arrhythmia or irregular heartbeat		
Neurologic/Psychiatric		
Seizure/Convulsions		
Stroke		
Neurologic problem		
Migraine headaches		
Depression		
Anxiety		
Emotional problems other – please describe		
Urinary Tract		
Urinary tract or Kidney infections		
Kidney stones		
Chronic Kidney Disease		
Skeletal		
Arthritis		
Pelvic/back fractures		
Gastrointestinal		
Vomiting that you needed medication to treat		
Irritable bowel syndrome		
Crohn's disease, ulcerative colitis		
Chronic constipation		
History of hepatitis, pancreatitis		
Gallstones		
Systemic		
Lupus/Sjogren's syndrome/connective tissue disease		
Sarcoidosis		
Rheumatoid arthritis		
Complications with anesthesia		Note family history of severe complications to anesthesia e.g., malignant hyperthermia:
Cancer (type)		If family member had breast cancer who?
Infections Disease		
Chickenpox		
Tuberculosis		
HIV/AIDS		
Hepatitis – note type		
Group B Strep (GBS)		
Gynecologic		
Infertility (cause if known)		
Abnormal pap smear		
History of pelvic inflammatory disease		
Genital herpes		
Gonorrhea, Chlamydia, Syphilis – note which		
Fibroids or Fibroid Removal		
Abnormaility with your uterus		
Dilation and Curettage (D&C)		
Surgical Removal of Ovary		

PREGNANCY RISK FACTORS – *Check any that apply*

High Risk Factors for Pre-Eclampsia
Your clinician may recommend Aspirin
- ☐ Diabetes
- ☐ Hypertension
- ☐ Kidney disease
- ☐ Current Pregnancy is twins or more
- ☐ Auto-immune disease (lupus, Sjogren's syndrome, rheumatic disease, thyroid disease or other)
- ☐ Previous pregnancy with high blood pressure (pre-eclampsia)
- ☐ Mother or sister who had preeclampsia

Other Risk Factors – *Interventions vary*
- ☐ Sleep apnea
- ☐ Current Smoker
- ☐ Current Pregnancy by IVF
- ☐ Last delivery less than 12 months ago
- ☐ Previous procedure to cervix (LEEP, Laser, Cone biopsy)
- ☐ Abnormal shape of uterus

Risk Factors for Pre-Term Birth
Your clinician may recommend Progesterone
- ☐ Previous Delivery before 37 weeks
- ☐ Family member with pre-term birth

SURGICAL HISTORY:

Have you ever had a procedure on your cervix (like cryo, cone, laser, or LEEP)? ☐ no ☐ yes___________

Circle if any of the following surgeries you have had**:** Appendectomy Bowel resection or other bowel surgery Kidney surgery Gallbladder surgery Other surgery on my abdomen (belly):_____________________________

FOOD/DIET

Have you ever had a problem with your weight? ☐ no ☐ yes→what kind of problem? _________________________

What was your weight prior to your pregnancy? ___________ Do you eat a special diet? ☐ no ☐ yes:________________

Do you ever experience unusual non-food cravings? ☐ no ☐ yes→explain__________________________________

Have you ever been diagnosed with an eating disorder? ☐ no ☐ yes→explain_______________________________

TOBACCO/VAPE USE

Do you currently smoke cigarettes? ☐ Never ☐ no, Quit Date Started:_____ Amt/PPD: ____ Date Stopped: ____

☐ yes Date Started: _____ Amt/PPD: ____

Do you use other forms of tobacco or vape? ☐ no ☐ yes→in a typical week: how much do you vape? ________

how much smokeless tobacco (like dip, chew, or snuff) do you use?__________

I have exposure to second hand smoke or vaping ☐ no ☐ yes→explain_______________________________

ALCOHOL AND DRUG USE

Have you <u>ever</u> used alcohol or drugs? ☐ no→*Skip to SAFETY* ☐ yes→*continue this section*

Before you were pregnant, how many alcoholic drinks do you have in an average week? ☐ none ☐ # ______________

Since you found out you were pregnant, how many alcoholic drinks have you had? ☐ none ☐ # __________________

What recreational drugs have you used? ☐ none ☐ marijuana ☐ heroin ☐ crack ☐ cocaine ☐painkillers ☐ other ________

Do you take any medications prescribed for someone else? ☐ no ☐ yes: _______________________________________

Do you take any of your prescription medication other than as directed? ☐ no ☐ yes: ___________________________

If yes to questions above, when was the last time you took any of these drugs or medications? _____________________

Have you ever used IV drugs? ☐ no ☐ yes

Does your partner have a problem with drug or alcohol use? ☐ no ☐ yes: ____________________________________

SAFETY

Do you wear seatbelts when in a car? □ no, not usually □ sometimes □ yes, always

Do you feel physically and emotionally safe where you currently live? □ yes □ no □ unsure

In the past year have you been afraid of your partner or ex-partner? □ yes □ no □ unsure

In general, how would you describe your relationship?

a. No tension

b. Some tension

c. A lot of tension

Do you and your partner work out arguments with...

a. No difficulty

b. Some difficulty

c. Great difficulty

ENVIRONMENTAL EXPOSURE (for current pregnancy):

Have you taken any medication since your last period? □ no □ yes ______________________________

Have you been exposed to any chemicals? □ no □ yes ______________________________________

Have you been exposed to any x-rays, lead or viral infection since your last period? □ no □ yes ___________________

Have you been exposed to any occupational or work-related risks? □ no □ yes ____________________

What pets do you have in your home? ____

FEELINGS ABOUT YOUR PREGNANCY/SENSITIVE ISSUES:

How do you feel about this pregnancy? ____

Are the most important people in your life (e.g., partner, family) supportive of this pregnancy? □ no □ yes

Have you ever experienced unwanted sexual touching and/or contact? □ no □ yes

Is there anything in your past that might make your visits with us scary, uncomfortable or traumatic? □ no □ yes

What is your current gender identity? □Female □Male □Transgender Male/Trans Man/FTM □Gender Queer □Other:

Over the past two weeks how often have you been bothered by any of the following problems?
-Little interest or pleasure in doing things __Not at All __Several Days __More than Half the Days __Nearly Every Day
-Feeling down, depressed or hopeless __Not at All __Several Days __More than Half the Days __Nearly Every Day

Please note anything else you think we should know about your previous pregnancies that is not captured on the next page, about your history in general or any other stresses:

____
____
____
____

OBSTETRICAL HISTORY: ONLINE IS NOT THIS DETAILED

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G__________ P___________
A ___________ L ___________

Total number of pregnancies _________________ *(Include current pregnancy, miscarriages, abortions and ectopic pregnancies)*

PREGNANCY	**FIRST**	**SECOND**	**THIRD**	**FOURTH**	**FIFTH**	**SIXTH**
DOB or Month/Year of Pregnancy						
Baby's Name						
Full-term birth						
Premature birth						
Multiple Birth (twins, etc.)						
Miscarriage						
Ectopic pregnancy						
Molar Pregnancy						
Induced abortion						
PREGNANCY COMPLICATIONS	*Place a check under the corresponding pregnancy if you experienced any of the following*					
NONE						
High blood pressure/Toxemia/Preeclampsia						
Bleeding or severe anemia						
Vomiting (excessive)						
Gestational Diabetes						
Bladder or Kidney Infection						
Treatment for premature labor						
Placenta Accreta						
Other:						
LABOR AND DELIVERY	**FIRST**	**SECOND**	**THIRD**	**FOURTH**	**FIFTH**	**SIXTH**
Type of Delivery:	*Place a check in the box that describes the delivery for each pregnancy*					
Vaginal						
Vaginal with Forceps						
Vaginal with Vacuum						
Cesarean Section						
	Fill in the information that applies to each birth under the appropriate column.					
Gestational age (# Weeks Pregnant)						
Birth weight						
Female/male						
Breast/bottle fed						
Current health status of child						
Induced labor						
Hours of labor						
Anesthesia used						
Place of Birth						
COMPLICATIONS	**FIRST**	**SECOND**	**THIRD**	**FOURTH**	**FIFTH**	**SIXTH**
LABOR & DELIVERY *(e.g., difficulty delivering baby's shoulders, anesthesia issues, episiotomy/laceration)*						
NONE						
Other – please describe						
POSTPARTUM						
NONE						
Breastfeeding problems						
Postpartum depression						
Other – please describe						
NEWBORN						
NONE						
Infection						
Other – please describe						
CHILDREN of FATHER of BABY - OTHER RELATIONSHIPS	**FIRST**	**SECOND**	**THIRD**	**FOURTH**	**FIFTH**	**SIXTH**
Child's Name						
Child's Age						
Note any health issues:						