Atrius Health

Initial OB Health Questionnaire

This health questionnaire used by your obstetric clinicians in developing a care plan during your pregnancy. It addresses health and social issues concerning you and your partner and will assist our clinical staff in helping you prepare for parenthood. ***Please answer all questions as thoroughly as possible and bring the completed questionnaire to your initial obstetric appointment. If you have MyHealth and answered the on-line questionnaire, you do not need to complete this paper form.*** *Your clinician will review this form with you & address any concerns you have regarding your pregnancy. You are welcome to bring your partner with you to obstetric appointments.*

Date: _____

For Clinician Use
PAS LABEL
Form Version: 1.23.19

PATIENT

Name: _____

Address: _____

_____

Telephone #: Cell: _____ (H) _____

(W):_____ Marital Status: _____

Place of Birth: _____

Work: *Choose one*
__Unemployed
__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: _____

What language are you most comfortable speaking?
_____

What is the highest level of school that you have finished?
__Less than High School Degree
__High School Diploma or GED
__More than High School

Number of people in your household? _____

Note name and DOB of all living in home:

#1_____DOB:_____
#2_____DOB:_____
#3_____DOB:_____
#4_____DOB:_____
#5_____DOB:_____
#6_____DOB:_____

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? _____ Was it normal? ☐ no ☐ yes

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

Type of birth control last used: _____ Date last used: _____

For Clinician Use

EDC by LMP:
EDC by U/S:
Adjusted EDC:

ENVIRONMENTAL EXPOSURE (for current pregnancy):

Have you taken any medication since your last period? □ yes □ no If yes, what? _____

Have you been exposed to any chemicals? □ yes □ no If yes, what? _____

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

If yes, explain: _____

Have you been exposed to any occupational or work-related risks? □ no □ yes If yes, explain: _____

What pets do you have in your home? _____

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 ___ Hispanic ___ Mediterranean ___Native American ___ Other (please specify) _____

Father of baby race/heritage: ___ African American/Black ___ Asian ____ Caucasian ___ Eastern-European Jewish ___Cajun ___French-Canadian ___ Hispanic ___ Mediterranean ___Native American ___ Other (please specify) _____

Age of baby's father: _____

Please indicate if the following applies to you or your family.

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					

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		
Endocrine		
High blood sugar (diabetes)		
Gland problems (thyroid, adrenal, pituitary)		
Respiratory		
Asthma (childhood/adult)		
Cardiac		
Heart murmur		
Rheumatic fever		
Mitral valve prolapse		
Heart attack		
Arrhythmia or irregular heartbeat		
Neurologic/Psychiatric		
Seizure		
Stroke		
Neurologic problem		
Migraine headaches		
Depression		
Anxiety		
Emotional problems other – please describe		
Urinary Tract		
Urinary tract or Kidney infections		
Kidney stones		
Skeletal		
Arthritis		
Pelvic/back fractures		
Gastrointestinal		
Irritable bowel syndrome		
Crohn's disease, ulcerative colitis		
Chronic constipation		
History of hepatitis, pancreatitis		
Gallstones		
Systemic		
Lupus/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		
Gynecologic		
Infertility (cause if known)		
Abnormal pap smear		
History of pelvic inflammatory disease		
Genital herpes		
Syphilis		
Gonorrhea or Chlamydia		
Fibroids		
Fibroid Removal		
Dilation and Curettage (D&C)		

Surgical Removal of Ovary		

PREGNANCY RISK FACTORS – *Check any that apply*

Risk Factors for Pre-Term Birth
Your clinician may recommend Progesterone

- ☐ Previous Delivery before 37 weeks

High Risk Factors for Pre-Eclampsia
Your clinician may recommend Aspirin

- ☐ Diabetes
- ☐ Hypertension
- ☐ Kidney disease

Other Risk Factors – *Interventions vary*

- ☐ Sleep apnea
- ☐ Current Smoker
- ☐ Current Pregnancy by IVF
- ☐ 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
- ☐ Current Pregnancy is twins or more
- ☐ Last delivery less than 12 months ago
- ☐ Previous procedure to cervix (LEEP, Laser, Cone biopsy)
- ☐ Abnormal shape of uterus

OPERATIONS, HOSPITALIZATIONS, MAJOR INJURIES:

Problem	*Date*	*Place*

SENSITIVE ISSUES:

How do you feel about this pregnancy? _____

Is your partner/family supportive of this pregnancy? _____

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

☐ I have exposure to second hand smoke ☐ yes Date Started: _____ Amt/PPD: ____

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? ☐ yes ☐ no: _____

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

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

For any, note when last used: _____

Have you ever used IV drugs? ☐ yes ☐ no

Have you used drugs with this pregnancy or within the past year? ☐ yes ☐ no How often? _____

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

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

Have you ever had a problem with your weight? ☐ yes ☐ no If yes, what kind of problem? _____

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

Do you ever experience unusual non-food cravings? ☐ yes ☐ no If yes, explain_____

Have you ever been diagnosed with an eating disorder? ☐ yes ☐ no If yes, explain_____

What is your housing situation today? ☐I have housing ☐I do not have housing (staying with others, in a hotel, in car, etc.)

Are you worried about losing your housing? ☐ yes ☐ no

In the past year, have you or any family members you live with been unable to get any of the following when it was really needed? Check all that apply:
☐ Food ☐ Utilities ☐ Clothing ☐ Child Care ☐ Medicine or any Health Care (Medical, Dental, Mental Health, Vision) ☐ Phone
☐ Other: _____

If you checked yes to any boxes above would you like to receive assistance with any of these needs? □ yes □ no

Are any of your needs urgent? (*for example, I don't have food tonight; I don't have a place to sleep tonight*) □ yes □ no

Has lack of transportation kept you from medical appointments, meetings, work or from getting things needed for daily living? Check all that apply:

- □ Yes it has kept me from medical appointments or from getting my medications
- □ Yes it has kept me from non-medical meetings, appointments, work or from getting things that I need
- □ No

How often do you see or talk to people that you care about and feel close to? (For example: talking to friends on the phone, visiting friends or family, going to church or club meetings)
□Less than once per week □1-2 times per week □3-5 times per week □5 or more times per week

In the past year have you spent more than 2 nights in a row in jail, prison, detention center or juvenile correction facility? □ yes □ no

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

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

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

How confident are you that you can control and manage most of your health problems? Please provide a numerical response between 0-10. 0=not at all confident 10=completely confident

1 2 3 4	5 6 7 8 9	10
Not confident	Somewhat Confident	Very Confident

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 any other stresses or anything else you think we should know about your history or previous pregnancies:

_____
_____
_____
_____

For Clinician Use

*G*_____ *P*_____

A _____ *L* _____

OBSTETRICAL HISTORY:

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:						