

Georgetown Ob-Gyn

Dr. Vincent Sherman

Dr. John Sherman

Dr. Kelly Montville

New Obstetric Patient Questionnaire

Date: _____

Name: _____ Birthdate: _____

Age: _____ Whom may we thank for referring you? _____

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

2. When was your first positive pregnancy test? _____

3. Please fill out below regarding any previous pregnancies.

Pregnancy	Date	Outcome (miscarriage, ectopic, vaginal delivery or C-section)	Complications
1 st			
2 nd			
3 rd			
4 th			
5 th			

4. Are you allergic to any medications? []Yes []No Are you allergic to latex? []Yes []No

If yes, explain which medication(s) and what type of reaction: _____

5. List all medications you have taken since you last period, including non-prescription, herbal remedies, and vitamins with doses and dates taken, if known.

6. Do you smoke? []Yes []No. If yes, how many cigarettes per day? _____

Do you drink alcohol? []Yes []No. If yes, what type and how much per week? _____

Do you use illegal drugs? []Yes []No. If yes, what time and how often? _____

7. Do you have any medical problems or any history of medical problems (ie. High blood pressure, cancer, thyroid disease)? _____

Check any of the problems that you or an immediate family member has?

	Self	Family member, who?
Heart disease or high blood pressure		
Diabetes		
Blood Clots		
Asthma		
Seizures		
Heart murmur		

8. Have you ever had any of the following?

	Yes or No	When?
Abnormal Pap smear?		
Chlamydia?		
Hepatitis?		
Gonorrhea?		
Genital herpes?		
Syphilis?		

9. List all surgeries you have had.

Surgery	When?	Why?

10. Have you been hospitalized for any reason other than childbirth and above listed surgeries? If yes, explain when and why. _____

11. Have you had chicken pox? [] Yes [] No. If yes, when (age)? _____

Have you had the Varicella (chicken pox) vaccine? [] Yes [] No. If yes, when? _____

12. When was your last?

Pap _____ Result _____

Mammogram _____ Result _____

Flu shot _____

Tetanus shot _____