MR#: ☐☐☐☐☐☐☐

Name of Patient:

Date of Birth:

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UNIVERSITY OF CALIFORNIA, DAVIS
MEDICAL CENTER
SACRAMENTO, CALIFORNIA

PATIENT QUESTIONNAIRE

Date Completed:_____

Name: _____ Date of Birth:_____ Age:_____

Language: ☐ English ☐ Other:_____ Race/Ethnicity: _____

Religion: _____

Martial Status: ☐ S ☐ M ☐ D ☐ W

Occupation: _____ ☐ Full-time ☐ Part-time ☐ Unemployed

Address: _____

City: _____ Zip: _____

Education: _____ Primary Care Provider: _____

Phone: Home: ( ) _____ Work: ( ) _____

Cell: ( ) _____ Message: ( ) _____

In Case of Emergency Contact:

Name: _____ Phone: ( ) _____

Relationship: _____

Name: _____ Phone: ( ) _____

Relationship: _____

Father of the Baby Information

Name: _____

Age: _____ Race/Ethnicity: _____

Occupation: _____

Phone: Home: ( ) _____ Work: ( ) _____

Cell: ( ) _____

Before Pregnancy

How tall are you?

What did you weigh before the pregnancy? lbs

What is your current weight? _____lbs

Medical History

Are you allergic to any prescription or over the counter medications? ☐ Yes ☐ No * if yes, list below

Medicine	Allergic Reaction

Are you allergic to latex? ☐ Yes ☐ No

If yes, what reaction do you have?_____

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What is your preferred pharmacy?_____

Where is your preferred pharmacy located?_____

How old were you when you started having periods?

How often do you have a period? Every _____ days

Are they ☐ Regular ☐ Irregular

When was the first day of your last period?_____

When did you have a positive pregnancy test?_____

How many days do they last?_____

Was this a normal period? ☐ Yes ☐ No

Did you use donated eggs for this pregnancy?_____

Prior Pregnancies

How many times have you been pregnant? _____

Date of 1st Delivery: _____

Baby's name: _____ ☐ Boy ☐ Girl

Baby's weight at delivery: _____ lbs _____ oz

How far along in pregnancy at delivery: _____ weeks or _____ months

Hours in labor:_____

Type of delivery: ☐ vaginal ☐ forceps ☐ vacuum ☐ c-section

Anesthesia: ☐ epidural ☐ spinal ☐ general

Complications: _____

Hospital of Delivery: City:

Date of 2nd Delivery: _____

Baby's name: _____ ☐ Boy ☐ Girl

Baby's weight at delivery: _____ lbs _____ oz

How far along in pregnancy at delivery: _____ weeks or _____ months

Hours in labor:_____

Type of delivery: ☐ vaginal ☐ forceps ☐ vacuum ☐ c-section

Anesthesia: ☐ epidural ☐ spinal ☐ general

Complications: _____

Hospital of Delivery: City:

Date of 3rd Delivery: _____

Baby's name: _____ ☐ Boy ☐ Girl

Baby's weight at delivery: _____ lbs _____oz

How far along in pregnancy at delivery: _____ weeks or _____ months

Hours in labor:_____

Type of delivery: ☐ vaginal ☐ forceps ☐ vacuum ☐ c-section

Anesthesia: ☐ epidural ☐ spinal ☐ general

Complications: _____

Hospital of Delivery: City:

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Date of 4th Delivery: _____

Baby's name: _____ ☐ Boy ☐ Girl

Baby's weight at delivery: _____lbs _____oz

How far along in pregnancy at delivery: _____ weeks or _____ months

Hours in labor:_____

Type of delivery: ☐ vaginal ☐ forceps ☐ vacuum ☐ c-section

Anesthesia: ☐ epidural ☐ spinal ☐ general

Complications: _____

Hospital of Delivery: City:

Date of 5th Delivery: _____

Baby's name: _____ ☐ Boy ☐ Girl

Baby's weight at delivery: _____lbs _____oz

How far along in pregnancy at delivery: _____ weeks or _____ months

Hours in labor:_____

Type of delivery: ☐ vaginal ☐ forceps ☐ vacuum ☐ c-section

Anesthesia: ☐ epidural ☐ spinal ☐ general

Complications: _____

Hospital of Delivery: City:

Have you ever had a miscarriage? ☐ Yes ☐ No

Date:_____ Months pregnant? _____

Date:_____ Months pregnant? _____

Date:_____ Months pregnant? _____

Have you ever had an abortion? ☐ Yes ☐ No

Date:_____ Months pregnant?_____

Date:_____ Months pregnant? _____

Date:_____ Months pregnant? _____

Have you ever had a tubal pregnancy? ☐ Yes ☐ No

Date: _____ Treatment: _____ Hospital: _____

Have you had prenatal care anywhere else during this pregnancy? ☐ Yes ☐ No

If yes, please list: Provider _____

Address _____

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Obstetrical History Please complete the following section if you have had a previous pregnancy.
With any of your other pregnancies did you have:

1. Anemia	☐ Yes ☐ No
2. Baby with defects or died during pregnancy/infancy	☐ Yes ☐ No
3. Diabetes in pregnancy	☐ Yes ☐ No
4. Heavy bleeding	☐ Yes ☐ No
5. Severe vomiting	☐ Yes ☐ No
6. Weak cervix	☐ Yes ☐ No
7. Baby didn't grow normally	☐ Yes ☐ No
8. Blood problems	☐ Yes ☐ No
9. Extra water around the baby	☐ Yes ☐ No
10. Postpartum depression	☐ Yes ☐ No
11. High blood pressure during pregnancy	☐ Yes ☐ No
12. Premature labor or birth	☐ Yes ☐ No
13. Bag of water broken early	☐ Yes ☐ No
14. Rhogam given	☐ Yes ☐ No
15. Blood type Rh negative	☐ Yes ☐ No
Gynecologic History	
16. What birth control have you used? ☐ pills ☐ patch ☐ shot ☐ IUD ☐ ring	
17. Have you ever had an abnormal pap smear? If yes, did you have treatment?_____	☐ Yes ☐ No
18. Have you had fibroids in your uterus?	☐ Yes ☐ No
19. Have you had a gynecologic surgery?	☐ Yes ☐ No
type:_____	
20. Have you had trouble getting pregnant or ever seen a fertility specialist?	☐ Yes ☐ No
21. Did your mother take DES or other hormones when she was pregnant with you?	☐ Yes ☐ No
22. Is there anything wrong with your uterus or cervix?	☐ Yes ☐ No
23. Have you ever had Chlamydia?	☐ Yes ☐ No
24. Have you ever had Gonorrhea?	☐ Yes ☐ No
25. Have you ever had Herpes?	☐ Yes ☐ No
26. Have you ever had Syphilis?	☐ Yes ☐ No
27. Have you ever had Trichomonas?	☐ Yes ☐ No
28. Have you ever had genital warts (HPV)?	☐ Yes ☐ No
29. Have you ever had a yeast infection?	☐ Yes ☐ No
30. Have you ever had Toxoplasmosis?	☐ Yes ☐ No
31. Have you ever had Group B Strep?	☐ Yes ☐ No
32. Have you ever had German measles? Rubella Vaccine? _____	☐ Yes ☐ No
33. Have you ever had chicken pox? Vaccine? _____	☐ Yes ☐ No
34. Have you ever had CMV? (Cytomegaly Virus)	☐ Yes ☐ No

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35. Do you have AIDS or HIV?	☐ Yes ☐ No
36. Have you ever had Hepatitis A?	☐ Yes ☐ No
Hepatitis A Vaccine?_____	☐ Yes ☐ No
Hepatitis B?	☐ Yes ☐ No
Hepatitis B Vaccine? _____	☐ Yes ☐ No
Hepatitis C?	☐ Yes ☐ No

Medical History

Do you have now or have you ever had any of the following? Check and indicate which family members have any of the conditions.

37. Heart attack	☐ patient	☐ family:_____	☐ none
38. Heart problems	☐ patient	☐ family:_____	☐ none
39. Rheumatic fever	☐ patient	☐ family:_____	☐ none
40. Heart valve problems	☐ patient	☐ family:_____	☐ none
41. High blood pressure	☐ patient	☐ family:_____	☐ none
42. Aorta problems	☐ patient	☐ family:_____	☐ none
43. Varicose veins or blood clot in the leg	☐ patient	☐ family:_____	☐ none
44. Blood clot in the lung	☐ patient	☐ family:_____	☐ none
45. Abnormal bleeding	☐ patient	☐ family:_____	☐ none
46. Anemia	☐ patient	☐ family:_____	☐ none
47. A blood transfusion	☐ patient	☐ family:_____	☐ none
Would you take a blood transfusion if your doctor thought it was necessary? ☐ Yes ☐ No			
48. Other medical problems	☐ patient:_____		
	☐ family: _____		☐ none
49. Asthma	☐ patient	☐ family:_____	☐ none
50. Tuberculosis	☐ patient	☐ family:_____	☐ none
51. Lung problems	☐ patient	☐ family:_____	☐ none
52. Diabetes	☐ patient	☐ family:_____	☐ none
53. Thyroid problems	☐ patient	☐ family:_____	☐ none
54. PKU	☐ patient	☐ family:_____	☐ none
55. Hormone/Endocrine problems	☐ patient	☐ family:_____	☐ none
56. Stomach or bowel problems	☐ patient	☐ family:_____	☐ none
57. Liver problems	☐ patient	☐ family:_____	☐ none
58. Bladder infections	☐ patient	☐ family:_____	☐ none
59. Kidney infections	☐ patient	☐ family:_____	☐ none
60. Urinary tract infections	☐ patient	☐ family:_____	☐ none
61. Kidney problems	☐ patient	☐ family:_____	☐ none
62. Lupus, Rheumatoid arthritis	☐ patient	☐ family:_____	☐ none
63. Cancer	☐ patient	☐ family:_____	☐ none
64. Stroke	☐ patient	☐ family:_____	☐ none
65. Seizures or Epilepsy	☐ patient	☐ family:_____	☐ none
66. Migraine headaches	☐ patient	☐ family:_____	☐ none
67. Multiple Sclerosis, Alzheimer's	☐ patient	☐ family:_____	☐ none

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68. Other brain or nerve problems	☐ patient	☐ family:_____	☐ none
69. Mental illness	☐ patient	☐ family:_____	☐ none

70. Is there anyone of your family or your friends that you are not safe with?	☐ Yes ☐ No
71. Have you ever been physically or emotionally abused?	☐ Yes ☐ No
72. Does anyone smoke or have a drug or alcohol problem?	☐ Yes ☐ No
73. Have you ever had a bad accident (broken bones, unconscious)?	☐ Yes ☐ No
74. Have you ever had an operation? Date:_____ Type:_____	☐ Yes ☐ No
75. Have you had problems with anesthesia?	☐ Yes ☐ No
76. Have you ever been hospitalized over night for anything besides a childbirth?	☐ Yes ☐ No
77. Do you have any other medical problems? Other_____	☐ Yes ☐ No
78. Will you be 35 years or older when you deliver?	☐ Yes ☐ No
79. Will baby's father be 50 or older when you deliver?	☐ Yes ☐ No

Have you, the baby's father or anyone in either family had:				
80. Cerebral Palsy	☐ patient	☐ father of baby	☐ family	☐ none
81. Cleft Lip or Palate	☐ patient	☐ father of baby	☐ family	☐ none
82. Birth defects	☐ patient	☐ father of baby	☐ family	☐ none
83. Heart problems	☐ patient	☐ father of baby	☐ family	☐ none
84. Are you related to the baby's father	☐ patient	☐ father of baby	☐ family	☐ none
85. Cystic Fibrosis	☐ patient	☐ father of baby	☐ family	☐ none
86. Downs Syndrome	☐ patient	☐ father of baby	☐ family	☐ none
87. Bleeding problems	☐ patient	☐ father of baby	☐ family	☐ none
88. Huntington's Chorea	☐ patient	☐ father of baby	☐ family	☐ none
89. Mental retardation	☐ patient	☐ father of baby	☐ family	☐ none
90. Muscular Dystrophy	☐ patient	☐ father of baby	☐ family	☐ none
91. Head or spine defect	☐ patient	☐ father of baby	☐ family	☐ none
92. Sickle cell disease or trait	☐ patient	☐ father of baby	☐ family	☐ none
93. Tay-sachs Disease (Jewish, Cajun)	☐ patient	☐ father of baby	☐ family	☐ none
94. Fragile X	☐ patient	☐ father of baby	☐ family	☐ none
95. Thalassemia (Italian, Greek, Mediterranean or Asian)	☐ patient	☐ father of baby	☐ family	☐ none
96. Autism	☐ patient	☐ father of baby	☐ family	☐ none
97. Other:_____	☐ patient	☐ father of baby	☐ family	☐ none

Since you became pregnant, have you had?	
98. Vaginal bleeding	☐ Yes ☐ No
99. Heartburn or stomach pain	☐ Yes ☐ No
100. Headache or dizziness	☐ Yes ☐ No
101. Change in vision	☐ Yes ☐ No
102. Severe vomiting	☐ Yes ☐ No

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103. Burning when urinating	☐ Yes	☐ No
104. Fever	☐ Yes	☐ No
105. Rash related to a viral illness	☐ Yes	☐ No
106. Injury or surgery	☐ Yes	☐ No
107. Other:_____	☐ Yes	☐ No

Since you became pregnant have you been exposed to		
108. Infections such as HIV, herpes, CMV, Syphillis	☐ Yes	☐ No
109. German measles or chicken pox	☐ Yes	☐ No
110. PKU	☐ Yes	☐ No
111. Encephalis	☐ Yes	☐ No
112. Chemicals (other than household cleaners)	☐ Yes	☐ No
113. X-rays	☐ Yes	☐ No
114. Cat litter, gardening, raw meat	☐ Yes	☐ No
115. Tuberculosis	☐ Yes	☐ No
116. Other: _____		

117. Do you drink alcohol? ☐ Yes ☐ No
What kind do you drink?_____
How much do you drink? _____
When was the last time you drank? _____

118. Do you smoke tobacco? ☐ Yes ☐ No
How much do you smoke? _____ When was the last time you smoked? _____

119. Do you take any over the counter drugs? ☐ Yes ☐ No
What type? _____
How often? _____

120. Do you take any prescription drugs? ☐ Yes ☐ No
What type? _____
How often? _____

121. Do you use any street drugs? ☐ Yes ☐ No
What type? _____
How often? _____ When was the last time you used drugs? _____

122. Do you plan to breastfeed? ☐ Yes ☐ No

123. Do you have a doctor for your baby? ☐ Yes ☐ No
Name: _____
Address: _____

Completed By: _____ _____
PATIENT SIGNATURE DATE

Reviewed By: _____ _____
PHYSICIAN SIGNATURE DATE