New Obstetrical Questionnaire

(updated 14 March 2019)

Name:	Primary Language:
Date of birth:	
Phone number:	
Ethnicity:	☐ Asian ☐ African American ☐ Caucasian ☐ Hispanic or Latino ☐ Native American ☐ Pacific Islander ☐ Other:
Marital Status:	☐ Married ☐ Separated ☐ Divorced ☐ Single ☐ Widowed
Where would you like to receive care?	☐ Fort Carson ☐ Peterson AFB ☐ Air Force Academy
What was your **weight** before pregnancy and your **height**?	
What was the **first day of your last menstrual period**?	

Have you ever had **infertility problems**?	☐ Yes	☐ No
Is this a **planned pregnancy**?	☐ Yes	☐ No
Do you have any **allergies**? Please list.	☐ Yes	☐ No

Immediate concerns

Are you currently having any **vaginal bleeding**?	☐ Yes	☐ No
Are you currently experiencing any significant **abdominal pain/cramping**?	☐ Yes	☐ No
Do you have a history of **ectopic pregnancy**?	☐ Yes	☐ No
Do you have a history of any **severe pelvic infections** requiring hospitalization?	☐ Yes	☐ No
Do you have a history of **pelvic surgery for either infertility or infection?**	☐ Yes	☐ No

Do you have any **chronic medical conditions** that require medication? Please list.	☐ Yes	☐ No

Pregnancy History

How many **pregnancies** have you had?		
Have you had any **miscarriages** and/or **elective abortions**?	☐ Yes	☐ No

Pregnancy History:

1. Date Delivered:
   Weeks pregnant:
   Vaginal or Cesarean: Duration of Labor:
   Birth Weight: Gender:
   Complications during pregnancy or delivery:

2. Date Delivered:
   Weeks pregnant:
   Vaginal or Cesarean: Duration of Labor:
   Birth Weight: Gender:
   Complications during pregnancy or delivery:

3. Date Delivered :
   Weeks pregnant:
   Vaginal or Cesarean: Duration of Labor:
   Birth Weight: Gender:
   Complications during pregnancy or delivery:

4. Date Delivered:
   Weeks pregnant:
   Vaginal or Cesarean: Duration of Labor:
   Birth Weight: Gender:
   Complications during pregnancy or delivery:

5. Date Delivered :
   Weeks pregnant:
   Vaginal or Cesarean: Duration of Labor:
   Birth Weight: Gender:
   Complications during pregnancy or delivery:

Medical History

Do you currently have or have you ever had **heart disease** or a **heart murmur**?	☐ Yes	☐ No
Do you currently have or have you ever had **rheumatic fever**?	☐ Yes	☐ No

Do you currently have or have you ever had **kidney or bladder problems, frequent urinary tract infections, or cystitis**?	☐ Yes	☐ No
Do you currently have or have you ever had **ulcers, stomach problems, or colitis**?	☐ Yes	☐ No
What year was your last **pap smear** done?		
Do you currently have or have you ever had an **abnormal Pap smear?** **COLPO?** **LEEP?**	☐ Yes	☐ No
Do you currently have or have you ever had **gynecological problems** such as **polycystic ovarian syndrome, endometriosis,** or **ovarian cysts**?	☐ Yes	☐ No
Do you currently have or have you ever had **high blood pressure**?	☐ Yes	☐ No
Do you currently have or have you ever had **pneumonia or asthma**?	☐ Yes	☐ No
Do you currently have or have you ever had **epilepsy or seizures**?	☐ Yes	☐ No
Do you currently have or have you ever had **migraine headaches**?	☐ Yes	☐ No
Do you currently have or have you ever had **thyroid problems**?	☐ Yes	☐ No
Do you currently have or have you ever had **diabetes?**	☐ Yes	☐ No
Do you currently have or have you ever had **varicose veins or blood clots in your leg?**	☐ Yes	☐ No
Do you currently have or have you ever had **bleeding tendencies**?	☐ Yes	☐ No
Have you ever had a **head injury** where you lost consciousness or had a **concussion**?	☐ Yes	☐ No
Do you have **trouble sleeping?**	☐ Yes	☐ No
Do you currently have or have you ever had **emotional problems / diagnosis**?	☐ Yes	☐ No
Have you ever attempted **suicide**?	☐ Yes	☐ No
Have you ever seriously thought about **hurting yourself**?	☐ Yes	☐ No
Have you ever been **hospitalized** for any reason? (childhood or adulthood)	☐ Yes	☐ No
Have you ever broken a **bone** or had a significant **orthopedic injury**?	☐ Yes	☐ No

Are you currently in need of or have you ever had a **surgery** or been placed under **anesthesia**? **Please list each procedure with year it was done.**	☐ Yes	☐ No

Infections

Do you currently have, have you ever had or been exposed to **hepatitis**?	☐ Yes	☐ No
Do you currently have, have you ever had or been exposed to t**uberculosis**, or have you lived with anyone who had tuberculosis?	☐ Yes	☐ No
Were you ever **stationed overseas**?	☐ Yes	☐ No
Were you **born outside of the United States**?	☐ Yes	☐ No
Have you ever had or been exposed to any **sexually transmitted infections** including Chlamydia, herpes, gonorrhea, syphilis, venereal warts, HPV or HIV?	☐ Yes	☐ No
Have you had a **rash or viral illness** since your last menstrual period?	☐ Yes	☐ No
Do you live in a house with **cats**?	☐ Yes	☐ No

Genetic Screening

Do you or the baby's father have a **birth defect**?	☐ Yes	☐ No
Will you be **35 years old or older** when the baby is due?	☐ Yes	☐ No
Is there a family history of **Down's syndrome** ?	☐ Yes	☐ No
Is there a family history of any other **chromosomal abnormality**?	☐ Yes	☐ No
Have you, the baby's father, or anyone in either of your families ever had a **Neural Tube Defect** such as Spina Bifida, or Meningomyelocele?	☐ Yes	☐ No
Have you, the baby's father, or anyone in either of your families ever had **Hemophilia or other Bleeding Disorders**?	☐ Yes	☐ No
Have you, the baby's father, or anyone in either of your families ever had **muscular dystrophy**?	☐ Yes	☐ No
Is there a family history of **multiple births**?	☐ Yes	☐ No
Have you, the baby's father, or anyone in either of your families ever had **Sickle cell anemia** or carry the **Sickle cell trait**?	☐ Yes	☐ No
Have you, the baby's father, or anyone in either of your families ever had **Cystic Fibrosis**?	☐ Yes	☐ No
Do you or the baby's father have any close relatives with **Mental retardation?**	☐ Yes	☐ No
Have you, the baby's father, or anyone in either of your families ever had **Anencephaly**?	☐ Yes	☐ No

Do you, the baby's father, or a close relative in either of your families have a **birth defect, family disorder, or a chromosomal abnormality not listed above**?	☐ Yes	☐ No
Has anyone ever had **heart murmurs** or **heart defects** in either family?	☐ Yes	☐ No

Family History

- Please include high blood pressure, diabetes, lung or heart disease, stroke, and all types of cancer!
- If the person is deceased, please list cause and age at time of death

What chronic or past health problems does your **Mother** have?	Alive? ☐ Yes ☐ No
What chronic or past health problems does your **Father** have?	Alive? ☐ Yes ☐ No
What chronic or past health problems does *your* **Maternal Grandmother** have?	Alive? ☐ Yes ☐ No
What chronic or past health problems does *your* **Maternal Grandfather** have?	Alive? ☐ Yes ☐ No
What chronic or past health problems does *your* **Paternal Grandmother** have?	Alive? ☐ Yes ☐ No
What chronic or past health problems does *your* **Paternal Grandfather** have?	Alive? ☐ Yes ☐ No
What chronic or past health problems do your **Brothers** or **Sisters** have?	Alive? ☐ Yes ☐ No

Social and Lifestyle History

Do you expect a **change in duty station, change in insurance, move** or **spouse deployment** during the pregnancy?	☐ Yes	☐ No
Do you **smoke or drink alcohol**?	☐ Yes	☐ No
Since becoming pregnant, have you been **exposed to any X-rays or toxic chemicals?**	☐ Yes	☐ No
Have you used **marijuana, LSD, speed, heroin, crystal, crack, or cocaine?**	☐ Yes	☐ No
LIST all medicines, vitamins, or supplements you have taken since becoming pregnant?		
Are you a **Vegetarian**?	☐ Yes	☐ No
Do you live with anyone who **hits or hurts you** in any way?	☐ Yes	☐ No

Do you have a history of **any Sexual or Physical Abuse** in your lifetime?	☐ Yes	☐ No
Do you wear **Seat Belts** while riding in automobiles?	☐ Yes	☐ No
Do you have any **HAZARDS** in your daily work or home environment? (If hazards are identified, nurse please place T-con to Occ. Health)	☐ Yes	☐ No
What is your **Highest level of Education**?		
What is your **Occupation**?		

This page was intentionally left blank

MEDICAL RECORD – CONSENT FORM

Cystic Fibrosis Carrier Test

For use of this form see MEDCOM Cir 40-16

I understand I am being asked to decide whether or not to have the cystic fibrosis carrier test. This test can identify if someone is a carrier of this disease.

By signing below I understand that—

1. This test is to see if I am a carrier of cystic fibrosis (CF). This means I could have the gene but not the disease.
2. The risk of being a CF carrier depends on race and ethnic background.
   a. For European Caucasian and Ashkenazi Jewish couples:
      (1) There is a 1 in 25 chance one parent is a carrier.
      (2) There is a 1 in 625 chance both parents are carriers.
   b. For Hispanic American couples:
      (1) There is a 1 in 46 chance one parent is a carrier.
      (2) There is a 1 in 2,116 chance both parents are carriers.
   c. For African American couples:
      (1) There is a 1 in 65 chance one parent is a carrier.
      (2) There is a 1 in 4,225 chance both parents are carriers.
   d. For Asian American couples:
      (1) There is a 1 in 80 chance one parent is a carrier.
      (2) There is a 1 in 8,100 chance both parents are carriers.
3. If I am a carrier of CF, testing the baby's biological father is needed to know if my baby could have CF.
4. CF carrier testing is one type of DNA testing. In the event the father is determined to be another person, a family medical history from that person will be necessary.
5. If both parents are carriers, the baby has a 1 in 4 (25%) chance of having CF. If this is the case, I may have more More testing to tell whether my baby has CF. This testing may be done before or after delivery.
6. I am the one to decide whether or not I am tested.
7. The test is not perfect. Some carriers are missed by the test.
8. My decision to have or not have this test will not change my military health coverage.

I have read and understand the information provided to me about cystic fibrosis. My questions have been answered to my satisfaction. Please check one:

☐ Yes, I want to have the cystic fibrosis carrier test.

☐ No, I do not want to have the cystic fibrosis carrier test.

Patient: _____ _____ _____
(Signature) (Print Name) (Date)

Witness: _____ _____ _____
(Signature) (Print Name) (Date)

This page was intentionally left blank

Relay Health – Secure Messaging

**This program is designed so that you can communicate with your provider, receive lab results, ask questions, etc.

Please legibly complete this form and return to a staff member so that we can register you! Thanks so much!

Name:_____

DOB:_____

Zip code:_____

DOD ID# (located on your military ID card):_____ E-

mail address (Legible please):

_____

Estimated Due Date:_____

“Care with Honor”