Lane OBGYN

Patient Survey

Congratulations on your pregnancy! In order to take care of you, we will need to know about any health problems that you might have. Please read the following questions and simply circle yes or no. You do not have to provide any details at this point. If have had even a small issue regarding any of these questions, please circle Yes. We will ask specific questions about your survey once it is submitted.

1. Have you ever had a blood transfusion?	Yes	No
2. Have you ever been placed on a medicine for a seizure disorder?	Yes	No
3. Do you have a problem with headaches?	Yes	No
4. Do you have any problems with your eyes or ears?	Yes	No
5. Do you have asthma?	Yes	No
6. Do you have any problems/issues with your lungs?	Yes	No
7. Do you have any health issues with your heart?	Yes	No
8. Do you have a condition called mitral valve prolapse?	Yes	No
9. Have you ever had rheumatic fever?	Yes	No
10. Have you had any problems with your thyroid.	Yes	No
11. Have you ever had high blood pressure?	Yes	No
12. Do you have diabetes?	Yes	No
13. Have you ever had hepatitis, gall stones, or liver problems?	Yes	No
14. Have you ever had ulcers or problems with your stomach?	Yes	No
15. Have you ever had problems with constipation?	Yes	No
16. Do you have any kidney problems?	Yes	No
17. Do you have a problem with bladder infections?	Yes	No
18. Do you have recurring rashes?	Yes	No
19. Have you ever had a blood clot in your legs?	Yes	No
20. Have you ever had arthritis or pain in your joints?	Yes	No
21. Have you ever had an abnormal pap smear?	Yes	No
22. Do you have any abnormalities with your uterus.	Yes	No
23. Have you ever had varicose veins?	Yes	No

24. Do you have any problems with your ovaries or tubes? Yes No

25. Have you had any sexually transmitted diseases, such as syphilis, gonorrhea, Chlamydia or HIV? Yes No

26. Have you ever had pelvic inflammatory disease, tubal infection, PID, pelvic infection or uterine infection? Yes No

27. Have you ever had herpes? Has your sexual partner ever had herpes? Yes No

28. Have you ever had cancer? Yes No

29. Have you ever been in a major accident? Yes No

30. If you were born before 1971, do you know if your mother took DES? Yes No

Did your mother have multiple miscarriages? Yes No

31. Have you ever had tuberculosis? Yes No

32. Do you have any psychiatric problems? Yes No

33. Do you smoke? Yes No

34. Do you drink alcohol? Yes No

35. Do you do illegal drugs? Yes No

37. Do you have any health problems at all? Yes No

38. Do you have any cats? Yes No

Part 2

The following questions should only be marked Yes if they have occurred since you have been pregnant.

1. **Have you been on any medicine?** Yes No
2. **Have you had any menstrual bleeding?** Yes No
3. **Have you had any abnormal discharge?** Yes No
4. **Have you had excessive vomiting?** Yes No

5. Have you been constipated?	Yes	No
6. Have you had headaches or abdominal pain?	Yes	No
7.Have you had a rash?	Yes	No
8. Have you had the flu?	Yes	No
9. Have you been sick in any way.	Yes	No

Part 3

1. Do you consider yourself Italian or Greek?	Yes	No
2. Does your family background come from Mediterranean or oriental type countries?	Yes	No
3. Does anyone in your family have spina bifida?	Yes	No
4. Is your family of Jewish decent?	Yes	No
5. Is there any sickle-cell anemia in your family?	Yes	No
6. Does anyone in your family have hemophilia or considered a free bleeder?	Yes	No
7. Are there any mental disabilities in your family?	Yes	No
8. Is there any cystic fibrosis in your family?	Yes	No
9. Are there any kinds of birth defects in your family?	Yes	No
10. Does anyone in your family have Huntington's Chorea?	Yes	No
11. Does anyone in your family have muscular dystrophy?	Yes	No

Sign _____

Date _____