The Delaware Center for Maternal and Fetal Medicine of Christiana Care
New Patient Questionnaire

Name	
Address	
DOB	Race
Partner's Name	
DOB	Race
Reason for Consultation	

Pregnancy History

Total # of Pregnancies ___________ Total # of Tubal Pregnancies _____________
Total # of Abortions _____________ Total # of Living Children _______________
Total # of Miscarriages __________
Total # of preterm deliveries (before 35 weeks) ____________

Pregnancy Record

Delivery Date/Due Date	Type of Delivery	Birth Weight	Complications

If you are currently pregnant, is this a new partner? ___________________________

Menstrual History

Age Menses began	Last menstrual period
Days between periods	Flow lasts
Flow is Light Medium	Heavy

Medical History

______	High Blood Pressure	______	Kidney Disease
______	Diabetes	______	Sickle Cell Disease
______	Heart Disease	______	Arthritis
______	Blood Clots	______	Migraine Headache
______	Pneumonia	______	Stroke
______	Tuberculosis	______	Mental Illness
______	Thyroid Disease	______	Sexually Transmitted Disease
______	Asthma	______	Herpes
______	Thyroid Disease	______	Vaginal Infections
______	Cancer	______	Abnormal PAP Screening
______	Hepatitis/Liver Disease	______	Endometriosis
______	Ulcers or stomach problems	______	History of Cancer
______	Bowel Problems	______	Birth Defect
______	Kidney Stones	______	Gall Bladder Disease
______	Blood Transfusion	______	Infertility

Family History

		Family Member
______	Cancer	______________________________
______	Tuberculosis	______________________________
______	High Blood Pressure	______________________________
______	Heart Disease	______________________________
______	Diabetes	______________________________
______	Stroke	______________________________
______	Thyroid Disease	______________________________
______	Birth defects/Mental Retardation	______________________________
______	Kidney Disease	______________________________
______	Asthma/Allergy	______________________________
______	Mental Illness	______________________________
______	Epilepsy/Seizure Disorders	______________________________
______	Blood Disorders/Blood Clots	______________________________
______	Other	______________________________

Surgical History

Date	Type of Surgery	Reason	Complication

Current Medications

Name of Medication	Prescribed by	Dose / Frequency	Reason for Medication

Allergy History

Allergy to Medications	Any Other Allergies

Are you currently under the care of a physician? ___________________________________

Physician ____________________ Last Seen _____________Reason ____________________

Dental History

Date of last exam	Problems/Concerns

Social History

Alcohol________________ Tobacco________________Illicit Drugs____________________

Please forward completed questionnaire via mail or fax to:

The Delaware Center for Maternal and Fetal Medicine
4755 Ogletown Stanton Road
Newark, DE 19718
Attn: Deborah Winder, RN

Or

Fax – 302-733-3635
Attn: Deborah Winder, RN