



Reston Pelvic
Surgery Associates

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Patient Questionnaire For New OB Visit

Today's date: _____

Patient's name (print): _____

Date of birth: _____

First date of your last menstrual period: _____

Was this a normal period? _____ Yes, _____ No. If not, how? _____
If not, first date of prior period: _____

Total no. of pregnancies including this one (include previous miscarriages, ectopic pregnancies and elective abortions): _____

Total no. of miscarriages: _____

Total no. of ectopic pregnancies: _____

Total no. of elective abortions, state if medically indicated: _____

Total no. of vaginal deliveries: _____

Total no. of cesarean deliveries: _____

Any vaginal delivery after cesarean section: _____

Total no. of children delivered at full term (between 37 weeks & the due date): _____

Total no. of children delivered preterm (between 20 weeks & less than 37 weeks): _____

Total no. of miscarriages (loss up to 20 weeks): _____

Total no. of still births (loss after 20 weeks): _____

Children that passed away after birth, cause(s) if known and their age: _____

Total number of biological children alive today: _____

When and how did you confirm this pregnancy: _____

Any pregnancy complications so far? _____