Pregnancy Questionnaire

NAME:_____ **DATE OF BIRTH:**_____

Although we may already have some of the information that we are asking for in this form, the initiation of prenatal care is an important time to thoroughly review your medical history and current health.

Is there a phone number(s) where we can leave confidential messages, such as test results/special instructions, for today's visit as well as for the future? If yes:

Phone Number:_____(home)_____(mobile) _____(work)

Name of Baby's Father:_____ Father's Phone Number:_____(home) _____(mobile) _____(work)

OBSTETRIC HISTORY:

Pregnancies: ___ # Deliveries: ___ # Abortions: ___ # Miscarriages: ___ # Ectopic Pregnancies: ___

First day of most recent period: (**LMP**) _____ Are your periods regular? ❑ Yes ❑ No

Positive hcg/pregnancy test? ❑ Yes ❑ No Did you have fertility treatment with this pregnancy? ❑ Yes ❑ No

If you took fertility medications, which one(s) did you take?_____

Pregnancies: (outcome is vaginal delivery, cesarian, miscarriage, abortion or ectopic)

	Date	Outcome	Gestation at time of delivery	Living	Hours in Labor	Weight of Baby	Sex	Name of Baby	Comments	Hospital	M.D.	Anesthesia
1												
2												
3												
4												
5												

Age at onset of menses: _____ Cycle:_____ days (start to start) Usual duration:_____ days

Flow: ❑ Light ❑ Medium ❑ Heavy Pain or cramps? ❑ Yes ❑ No

PAST OR CURRENT MEDICAL PROBLEMS:

Please check one	Yes	No	Please check one	Yes	No
diabetes			rheumatoid arthritis, lupus		
high blood pressure			infertility		
heart disease			urinary incontinence		
varicose veins, blood clots in veins			uterine abnormalities		
anemia, blood disorder			abnormal pap		
neurological problem, seizures			trauma, violence		
migraines			psychiatric problems		
allergies, hay fever, chronic sinusitis			anxiety, panic attacks		
autoimmune disease			depression, postpartum depression		
hepatitis, liver disease			sexually transmitted disease		
thyroid disorder			herpes		
kidney or bladder disease			HIV		
lung problem, asthma, tuberculosis			blood transfusion		
breast problems					

Other Medical Problems:_____

Details of positive responses: _____

_____

SURGERIES AND APPROXIMATE DATES (month/year):

1._____ 3._____

2._____ 4._____

IMMEDIATE FAMILY MEMBERS WHO HAVE:

Diabetes_____
High blood pressure_____
Heart attack/stroke_____
High cholesterol_____
Breast/ovarian cancer_____
Dementia/Alzheimer's_____
Colon cancer_____
Prostate cancer_____
Thyroid cancer_____
Alcoholism_____
Depression/suicide_____
Other_____

SOCIAL HISTORY:

Have you ever smoked? ❑ Yes ❑ No ❑ Current smoker ❑ Quit (month/year):_____

If yes, how many packs per day? ❑ <1 ❑ 1 ❑ 2 ❑ >3 For how many years?_____

Do you drink alcohol? ❑ Yes ❑ No If yes, how many drinks per week? ❑ <1 ❑ 1-4 ❑ 5-10 ❑ >20

Have you ever used recreational drugs? ❑ Yes ❑ No If yes, what drug(s)_____

Method of birth control prior to pregnancy:_____

Who lives at home with you?_____

Do you own cats? ❑ Yes ❑ No

If you have a partner, has he or she ever hit you, kicked you or threatened to harm you? ❑ Yes ❑ No

What is your occupation?_____

Are you exposed to any occupational chemicals? ❑ Yes ❑ No If yes, which chemical(s) _____

Marital status: ❑ Single ❑ Partnered/Married ❑ Divorced ❑ Widowed ❑ Other

If you have a domestic partner/spouse, what is his or her name?_____

Highest level of education: ❑ Elementary ❑ Junior High ❑ High School ❑ College ❑ Graduate School

HEALTH CARE MAINTENANCE TESTS

Last Pap smear (month/year): _____ ❑ Normal ❑ Abnormal

MEDICATION ALLERGIES/REACTION _____

_____

MEDICATIONS: (prescription medications, birth control, aspirin, vitamins/herbals, supplements) Everything since your last period

Medication	Dose (mg.)	Times per day	Medication	Dose (mg.)	Times per day
1.			3.		
2.			4.		

**Is there anything confidential you would like to discuss in private with your provider? ❑ Yes ❑ No

PRENATAL GENETIC SCREENING:

Mother of Baby
Is your ancestry:

- ❑ African American
- ❑ French Canadian
- ❑ Jewish
- ❑ Italian, Greek, Middle Eastern
- ❑ Asian
- ❑ Hispanic
- ❑ Filipino
- ❑ Other_____

Father of Baby
Is his ancestry:

- ❑ African American
- ❑ French Canadian
- ❑ Jewish
- ❑ Italian, Greek, Middle Eastern
- ❑ Asian
- ❑ Hispanic
- ❑ Filipino
- ❑ Other _____

Please answer all questions:

	Yes	No	Don't Know
Will you be 35 years old or older when the baby is due?			

Have you, the baby's father or anyone in either family ever had any one of the following disorders:

	Yes	No	Don't Know
A. Thalasemia	❒	❒	❒
B. Neural Tube Defect, Spina Bifida (Open Spine), Anencephaly	❒	❒	❒
C. Congenital Heart Defect	❒	❒	❒
D. Down Syndrome	❒	❒	❒
E. Tay-Sachs	❒	❒	❒
F. Canavan Disease	❒	❒	❒
G. Sickle Cell Disease or Trait	❒	❒	❒
H. Hemophilia or Blood Disorder	❒	❒	❒
I. Muscular Dystrophy	❒	❒	❒
J. Cystic Fibrosis	❒	❒	❒
K. Huntington's Chorea	❒	❒	❒
L. Mental Retardation	❒	❒	❒
M. Any other Genetic or Chromosomal Disorder	❒	❒	❒

Do you, the baby's father or a close family member of either of you have a birth defect or a chromosomal abnormality not listed above? ❒ Yes ❒ No ❒ Don't Know

Have you or the baby's father had a stillborn baby or three or more first trimester miscarriages?
❒ Yes ❒ No ❒ Don't Know

If you answered yes to any of the above questions, please indicate the condition and the relationship of the affected person to you or the baby's father: _____

INFECTION SCREENING:	Yes	No	Don't Know
Do you live with someone with TB or have you been exposed to TB?	❑	❑	❑
Do you or your partner have genital herpes?	❑	❑	❑
Have you had a rash or viral illness since your last period?	❑	❑	❑
Have you had Gonorrhea, Chlamydia, HPV or Syphilis?	❑	❑	❑
Have you had the chicken pox or varicella vaccine?	❑	❑	❑

Signature_____ Date _____