

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					

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:

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

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	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
B. Neural Tube Defect, Spina Bifida (Open Spine), Anencephaly	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
C. Congenital Heart Defect	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
D. Down Syndrome	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
E. Tay-Sachs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
F. Canavan Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
G. Sickle Cell Disease or Trait	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
H. Hemophilia or Blood Disorder	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I. Muscular Dystrophy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
J. Cystic Fibrosis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
K. Huntington's Chorea	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
L. Mental Retardation.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
M. Any other Genetic or Chromosomal Disorder	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

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?.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Do you or your partner have genital herpes?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Have you had a rash or viral illness since your last period?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Have you had Gonorrhea, Chlamydia, HPV or Syphilis?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Have you had the chicken pox or varicella vaccine?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Signature _____ Date _____

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