



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)

Table with 13 columns: Date, Outcome, Gestation at time of delivery, Living, Hours in Labor, Weight of Baby, Sex, Name of Baby, Comments, Hospital, M.D., Anesthesia. Rows 1-5.

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:

Table with 6 columns: Please check one, Yes, No, Please check one, Yes, No. Lists various medical conditions like diabetes, high blood pressure, heart disease, etc.

Other Medical Problems: _____

Details of positive responses: _____

SURGERIES AND APPROXIMATE DATES (month/year):

- 1. _____ 3. _____
- 2. _____ 4. _____

IMMEDIATE FAMILY MEMBERS WHO HAVE:

- | | |
|-----------------------------|--------------------------|
| Diabetes _____ | Colon cancer _____ |
| High blood pressure _____ | Prostate cancer _____ |
| Heart attack/stroke _____ | Thyroid cancer _____ |
| High cholesterol _____ | Alcoholism _____ |
| Breast/ovarian cancer _____ | Depression/suicide _____ |
| Dementia/Alzheimer's _____ | 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:

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 _____