



Pat. Name _____

Date of Birth _____

Patient I.D. _____

Physician _____

AFFIX LABEL HERE

PREGNANCY QUESTIONNAIRE

Date Age Race

Contact Number Primary Language Irregular Periods Date of Last Period Date of Last PAP

* PLEASE ANSWER OR CHECK NONE BOX

* Drug Allergies NONE

* Current Medications NONE

* Past Surgeries NONE

* Medical Problems NONE

Family History

WHO IN YOUR FAMILY (Living or Deceased) HAS OR HAS HAD THE FOLLOWING ILLNESSES OR MEDICAL CONDITIONS

Table with columns for Mother, Father, Maternal Grandmother, Maternal Grandfather, Paternal Grandmother, Paternal Grandfather and rows for various medical conditions like Breast Cancer, Ovarian Cancer, etc.

- Screening Questions: 1. Do you smoke or live with someone who smokes? 2. Are there any cats in the home? 3. Do you work in close contact with children? 4. Are you or the father of the baby of Jewish ancestry? 5. Do you have any work/environmental exposure concerns? 6. Do you have any concerns about domestic violence? 7. Have you taken any medications other than prenatal vitamins since your last menstrual period?

Medical History

- Medical History: 1. Do you have a seizure disorder? 2. Do you have any history of metabolic disorders (i.e. diabetes, insulin resistance or thyroid problems)? 3. Have you ever had a blood clot in your legs or chest? 4. Have you ever had a mental health diagnosis? 5. Do you have any history of alcohol or drug abuse? 6. Do you have any chronic medical problems (i.e. high blood pressure, asthma, hepatitis, heart disease)? Other: _____

OVER

Check one
Y=Yes N=No

Infection Screening

- Y N 1. Have you ever had chicken pox or varicella vaccine?
- Y N 2. Is there any exposure to tuberculosis (TB)?
- Y N 3. Do you have any history of sexually transmitted diseases (STD) exposure?
- Y N 4. Do you or your partner have a history of genital herpes?

Genetic Screening (Includes patient, baby's father and anyone in either family)

Check one
Y=Yes N=No

Check one
Y=Yes N=No

- | | | | |
|---|---------------------------------|---|---------------------------------|
| <input type="checkbox"/> Y <input type="checkbox"/> N | 1. Thalassemia | <input type="checkbox"/> Y <input type="checkbox"/> N | 8. Hemophilia or blood disorder |
| <input type="checkbox"/> Y <input type="checkbox"/> N | 2. Neural tube defect | <input type="checkbox"/> Y <input type="checkbox"/> N | 9. Muscular dystrophy |
| <input type="checkbox"/> Y <input type="checkbox"/> N | 3. Congenital heart defect | <input type="checkbox"/> Y <input type="checkbox"/> N | 10. Cystic fibrosis |
| <input type="checkbox"/> Y <input type="checkbox"/> N | 4. Down syndrome | <input type="checkbox"/> Y <input type="checkbox"/> N | 11. Huntington's chorea |
| <input type="checkbox"/> Y <input type="checkbox"/> N | 5. Tay-Sachs | <input type="checkbox"/> Y <input type="checkbox"/> N | 12. Mental handicap |
| <input type="checkbox"/> Y <input type="checkbox"/> N | 6. Canavan's disease | <input type="checkbox"/> Y <input type="checkbox"/> N | 13. Other chromosomal disorder |
| <input type="checkbox"/> Y <input type="checkbox"/> N | 7. Sickle cell disease or trait | <input type="checkbox"/> Y <input type="checkbox"/> N | 14. Other birth defect |

Pregnancy Summary

_____ # of pregnancies	_____ # of miscarriages	_____ # of twins/multiples
_____ # of full term	_____ # of abortions	_____ # of living children
_____ # of premature	_____ # of ectopic/tubal	

Date of Delivery	Weeks at Time of Delivery	Hours of Labor	Birth Weight	Sex of Child	Type of Delivery	Epidural / Anesthesia	Doctor's Name

Check one
Y=Yes N=No

History of Pregnancy Complications

- Y N 1. Any history of recurrent miscarriages, a stillbirth or a placental abruption?
- Y N 2. Any history of preterm labor or contractions?
- Y N 3. Any history of preterm delivery <37 weeks or water breaking?
- Y N 4. Any history of a baby that weighed less than 5 1/2 pounds?
- Y N 5. Any history of twins, triplets, or quads?
- Y N 6. Any history of high blood pressure with pregnancy?
- Y N 7. Any history of diabetes with pregnancy?
- Y N 8. Any history of an ectopic/tubal pregnancy?