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 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: __________________________ AGE: _____

FATHER'S PHONE NUMBER: Home: ____________ Mobile: ______________ Work: ______________

OBSTETRIC HISTORY:

Pregnancies: _____ # Deliveries: _____ # Abortions: _____ # Miscarriages: _____ # Ectopic: _____

First day of most recent period **(LMP)**: ____________ How certain are you? ____________________

Positive HCG/ Pregnancy test: ❑ Yes ❑ No Date: ________

Were you using birth control at time of conception? ______________________________________

Did you have fertility treatment with this pregnancy: ❑ Yes ❑ No If you took fertility medication,

which one(s) did you take? ____

PREGNANCIES: (Outcome is vaginal delivery, cesarean, miscarriage, abortion or ectopic)

	Date	Outcome	Wks at time of delivery	Living	Hrs in Labor	Weight of Baby	Sex	Name of Baby	Hospital	Doctor	Anesthesia	Comments
1												
3												
4												
5												

Which hospital do you prefer: ❑ Wesley Medical Ctr ❑ Wesley Birth Care Suites ❑ Via Christi St Joseph

What type of deliver is expected? ❑ Vaginal Delivery ❑ Cesarean Section

Are you planning on an epidural block during labor? ❑ Yes ❑ No

Do you intend to breast feed? ❑ formula feed? ❑

Who will be your baby's pediatrician? ______________________________

GYNECOLOGIC HISTORY:

Are your periods regular? ❑ Yes ❑ No

Age at onset of menses: ______ Cycle (start to start): ________days Usual duration: __________ days

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

MEDICATION ALLERGIES/ REACTION:

____

____

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

Medication	Dose (mg.)	Times per day	Medication	Dose (mg.)	Times per day

1. ______________________ 2. ______________________

3. ______________________ 4. ______________________

HEALTH CARE MAINTENANCE TESTS:

Last Pap smear (month/year): ____________ ☐ Normal ☐ Abnormal

PAST OR CURRENT MEDICAL PROBLEMS:

Please check one	Yes	No	Please check one	Yes	No
History of Abnormal Pap Smear			Heart disease		
Allergies, hay fever, chronic sinusitis			Hepatitis, liver disease		
Anemia			Infertility		
Anxiety, Panic Attacks			Kidney or bladder disease		
Asthma			Lung problems tuberculosis		
Autoimmune disease			Migraine Headaches		
Blood Disorder			Neurological problem, seizures		
Blood transfusion			Psychiatric problems		
Breast problems			Recent Surgery or X-rays		
History of surgery on Cervix			Rheumatoid arthritis, Lupus		
Depression, Postpartum Depression			Thyroid disorder		
Diabetes			Trauma, violence		
Diabetes in Pregnancy			Urinary incontinence		
High Blood Pressure			Uterine abnormalities		
High Blood Pressure in Pregnancy			Varicose veins, blood clots in veins		

Other Medical Problems: ____

Details of positive responses ____

____

SURGERIES AND APPROXIMATE DATES (month/year):

1. ______________________ 2. ______________________

3. ______________________ 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: ❑ Yes ❑ No 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, are you currently using drugs? ❑ Yes ❑ No

What drug(s) and for how long? ____

Who lives at home with you? ____

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

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

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

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

What is your occupation: ____

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

Do you have cats? ❑ Yes ❑ No If yes, who changes the litter box? ________________

Are you a Jehovah Witness? ❑ Yes ❑ No If yes, would you accept a blood transfusion if needed? ❑ Yes ❑ No

Do you wear your seat belt? ❑ Yes ❑ No

PRENATAL GENETIC SCREENING:

Mother of Baby: Is your ancestry:

❑ African American ❑ Asian

❑ French Canadian ❑ Hispanic

❑ Jewish ❑ Filipino

❑ Italian, Greek, Middle Eastern ❑ Other ________

Father of Baby: Is his ancestry:

❑ African American ❑ Asian

❑ French Canadian ❑ Hispanic

❑ Jewish ❑ Filipino

❑ Italian, Greek, Middle Eastern ❑ Other ________

Please answer all questions:

Will you be 35 years old or older when the baby is due? ____________

Have you or the baby's father had a stillborn baby or three or more first trimester miscarriages?

❑ Yes ❑ No ❑ Don't know

Do you desire Carrier screening for inherited genetic disorders? ❑ Yes ❑ No ❑ Don't know

Do you desire genetic testing: Cell-free fetal DNA (cffDNA) testing? ❑ Yes ❑ No ❑ Don't know

(See additional information on these available testing options)

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

	Disorder	Yes	No	Don't Know
A.	Thalassemia	❑	❑	❑
B.	Neural Tube Defect, Spinal 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.	Intellectual Disability	❑	❑	❑
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

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: ______________________________

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INFECTION HISTORY:

Question	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 ever had cold sores?	❑	❑	❑
Have you had Chlamydia or Gonorrhea?	❑	❑	❑
Have you had Syphilis?	❑	❑	❑
Do you or your partner have HIV?	❑	❑	❑
Have you or your partner been diagnosed with HPV?	❑	❑	❑
Have you received the HPV vaccine series ?	❑	❑	❑
Have you or your partner ever had Hepatitis?	❑	❑	❑
Have you received the Hepatitis vaccine?	❑	❑	❑
Have you had the chicken pox or varicella vaccine?	❑	❑	❑
Have you had a fever or rash since your last period?	❑	❑	❑
Have you had any illness since your last period?	❑	❑	❑

For any questions answered yes please provide additional information: ______________________________

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