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|  | Date: |  |
| Prenatal Intake QUESTIONNAIRE |
| All questions contained in this questionnaire are strictly confidential and will become part of your medical record. |
| Name: |  | **Date of Birth:** |
| Address:  |  | **Cell:** |
| Emergency contact and phone: |  | **Email:** |
|  |
| Demographic information |
|  |
| Marital status: | 🞎 Married 🞎 Single 🞎 Domestic Partner 🞎 Separated 🞎 Divorced 🞎 Widowed 🞎 Other  |
| **Ethnicity:** |  |  | **Reproductive partner’s ethnicity:** |
| **Occupation:** |  | **Employer:** |  |
|  |  |  |  |
| Ob/Gyn Status |
|  |  |  |  |
| First day of last period: | Are you currently breastfeeding? 🞎 yes 🞎 no | # of prior pregnancies:  |
| # of prior deliveries: | # of prior miscarriages/abortions: | # of living children: |
|  |  |  |  |
| Pregnancy circumstances |
| Living situation: 🞎 With reproductive partner 🞎 with domestic partner 🞎 Parents 🞎 Relatives 🞎 Friends 🞎 Alone 🞎 Other  |
| Name of significant other/partner:  |
| Is this the biological father? 🞎 yes 🞎 no | Is this a surrogate pregnancy? 🞎 yes 🞎 no | Will this baby be placed 🞎 yes 🞎 nofor adoption? |
| Is your living situation unsafe? 🞎 yes 🞎 no | Have you ever been hit, kicked 🞎 yes 🞎 noOr slapped by your partner? | Are you in a relationship 🞎 yes 🞎 no that physically threatens you? |
| History of fertility treatment? 🞎 yes 🞎 no | Was pregnancy concieved with 🞎 yes 🞎 nodonor sperm or donor egg?  | Is this a donor embryo? 🞎 yes 🞎 no |
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| Medical and Surgical History |
| Have you ever had any of the following conditions? Check Yes or No |
| Abnormal Pap test/HPV **🞎 yes 🞎 no**  | Diabetes, type I or II **🞎 yes 🞎 no** | Lung disease **🞎 yes 🞎 no** |
| Anemia **🞎 yes 🞎 no** | High blood pressure **🞎 yes 🞎 no** | Lupus **🞎 yes 🞎 no** |
| Blood transfusion **🞎 yes 🞎 no** | Hepatitis B or C **🞎 yes 🞎 no** | Rheumatoid Arthritis **🞎 yes 🞎 no** |
| Excessive bleeding or bruising **🞎 yes 🞎 no** | HIV positive/Partner is HIV pos **🞎 yes 🞎 no** | Crohn’s /ulcerative colitis **🞎 yes 🞎 no** |
| Blood clot in a vein (DVT) **🞎 yes 🞎 no** | Genital warts **🞎 yes 🞎 no** | Tuberculosis **🞎 yes 🞎 no**  |
| Blood clot in your lung (PE) **🞎 yes 🞎 no**  | Chlamydia or Gonorrhea **🞎 yes 🞎 no**  | Depression/Anxiety **🞎 yes 🞎 no**  |
| Cancer **🞎 yes 🞎 no** | Syphilis **🞎 yes 🞎 no** | Migraine Headaches **🞎 yes 🞎 no** |
| Chicken Pox **🞎 yes 🞎 no** | Kidney stones **🞎 yes 🞎 no** | Infertility **🞎 yes 🞎 no** |
| Chicken Pox Vaccine **🞎 yes 🞎 no** | Kidney infection (pyelonephritis) **🞎 yes 🞎 no** | Seizures/Epilepsy **🞎 yes 🞎 no** |
| Gestational Diabetes **🞎 yes 🞎 no** | Asthma **🞎 yes 🞎 no** | Thyroid problem **🞎 yes 🞎 no** |
| History of Pre-eclampsia Yes NO |  |  |
| Past Surgeries |
| Procedure | Month/Year | Hospital |
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| Family history |
| Has anyone in your family been diagnosed with the following? Check Yes or No |
| Spinda bifida or spinal defect **🞎 yes 🞎 no**  | Muscular dystrophy **🞎 yes 🞎 no**  | Huntington’s Chorea **🞎 yes 🞎 no** |
| Congenital heart defect **🞎 yes 🞎 no** | Cystic Fibrosis **🞎 yes 🞎 no** | Autism or Mental Retardation **🞎 yes 🞎 no** |
| Down Syndrome **🞎 yes 🞎 no** | Canavan’s Disease **🞎 yes 🞎 no** | Fragile X Disease **🞎 yes 🞎 no** |
| Abnormal chromosome/Trisomy **🞎 yes 🞎 no** | Sickle Cell Trait or Disease **🞎 yes 🞎 no** | Type I Diabetes **🞎 yes 🞎 no**  |
| Tay-Sachs disease **🞎 yes 🞎 no** | Another blood disorder **🞎 yes 🞎 no** | PKU/Phenylketonuria **🞎 yes 🞎 no** |
| Familial Dysautonomia **🞎 yes 🞎 no**  | Hemophilia **🞎 yes 🞎 no** | Recurrent pregnancy loss **🞎 yes 🞎 no** |
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| Is your family or your partner’s family of Ashkenazi Jewish descent? **🞎 yes 🞎 no** |
| Is your family or your partner’s family of Cajun or French Canadian descent? **🞎 yes 🞎 no** |
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| Past deliveries  |
| Pregnancy # 1  |
| Outcome: 🞎 Delivered Baby 🞎 Miscarriage 🞎 Termination 🞎 Ectopic Pregnancy **Living?** 🞎 Yes 🞎 No 🞎 Stillborn 🞎 Neonatal demise  |
|  🞎 Vaginal delivery 🞎 C-section 🞎 Vacuum or Forceps Vaginal delivery Reason for C-section: |
| Epidural Anesthesia? 🞎 Yes 🞎 No  | Length of Pregnancy (weeks): | Length of labor:  |
| Sex of Baby: 🞎 Male 🞎 Female  | Birthdate: | Birth weight:  |
| Child’s name:  | Issues with pregnancy or delivery: |
|  |
| Pregnancy # 2  |
| Outcome: 🞎 Delivered Baby 🞎 Miscarriage 🞎 Termination 🞎 Ectopic Pregnancy **Living?** 🞎 Yes 🞎 No 🞎 Stillborn 🞎 Neonatal demise  |
|  🞎 Vaginal delivery 🞎 C-section 🞎 Vacuum or Forceps Vaginal delivery Reason for C-section: |
| Epidural Anesthesia? 🞎 Yes 🞎 No  | Length of Pregnancy (weeks): | Length of labor:  |
| Sex of Baby: 🞎 Male 🞎 Female  | Birthdate: | Birth weight:  |
| Child’s name:  | Issues with pregnancy or delivery: |
|  |
| Pregnancy # 3  |
| Outcome: 🞎 Delivered Baby 🞎 Miscarriage 🞎 Termination 🞎 Ectopic Pregnancy **Living?** 🞎 Yes 🞎 No 🞎 Stillborn 🞎 Neonatal demise  |
|  🞎 Vaginal delivery 🞎 C-section 🞎 Vacuum or Forceps Vaginal delivery Reason for C-section: |
| Epidural Anesthesia? 🞎 Yes 🞎 No  | Length of Pregnancy (weeks): | Length of labor:  |
| Sex of Baby: 🞎 Male 🞎 Female  | Birthdate: | Birth weight:  |
| Child’s name:  | Issues with pregnancy or delivery: |

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| List your prescribed drugs and over-the-counter drugs, such as vitamins and inhalers |
| Name the Drug | Strength | Frequency Taken |
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| Allergies to medications |
| Medication or allergen | Reaction  |
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| Any history of ectopic pregnancy? | Yes | No |  |
| Any history of preterm labor/delivery? | Yes | No |  |
| Any history of neonatal loss? | Yes | No |  |
| Any history of still born? | Yes | No |  |
| Currently having Nausea? | Yes | No |  |
| Currently having Vomiting? | Yes | No |  |
| Had any vaginal bleeding since last menses? | Yes | No |  |
|  |  |  |  |