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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 🞎 no  for adoption? | | | |
| Is your living situation unsafe? 🞎 yes 🞎 no | | | | Have you ever been hit, kicked 🞎 yes 🞎 no  Or 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 🞎 no  donor sperm or donor egg? | | | Is this a donor embryo? 🞎 yes 🞎 no | | | |
|  | | | |  | | |  | | | |
| 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** | | | |
|  | | |  | | | |  | | | |
| 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 |  |
|  |  |  |  |