LOUISIANA WOMEN'S Healthcare

PREGNANCY QUESTIONNAIRE

Patient ID _____

Date _____

Patient Name	Physician	Date of Birth	Age	Race

Contact Number	Primary Language	Irregular Periods ☐ Yes ☐ No	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

	Mother	Father	Maternal Grandmother	Maternal Grandfather	Paternal Grandmother	Paternal Grandfather
Breast Cancer	☐	☐	☐	☐	☐	☐
Ovarian Cancer	☐	☐	☐	☐	☐	☐
Uterine Cancer	☐	☐	☐	☐	☐	☐
Other Female Cancer	☐	☐	☐	☐	☐	☐
Colon Cancer	☐	☐	☐	☐	☐	☐
Birth Defects	☐	☐	☐	☐	☐	☐
Sickle Cell Anemia	☐	☐	☐	☐	☐	☐
Mental Retardation	☐	☐	☐	☐	☐	☐

	Mother	Father	Maternal Grandmother	Maternal Grandfather	Paternal Grandmother	Paternal Grandfather
Diabetes	☐	☐	☐	☐	☐	☐
Epilepsy	☐	☐	☐	☐	☐	☐
Heart Disease	☐	☐	☐	☐	☐	☐
High Blood Pressure	☐	☐	☐	☐	☐	☐
Mental Illness	☐	☐	☐	☐	☐	☐
TB (Tuberculosis)	☐	☐	☐	☐	☐	☐
Other	☐	☐	☐	☐	☐	☐
List Other:						

Screening Questions

CHECK ONE Y=Yes N=No

☐ ☐ 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

☐ ☐ 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

Infection Screening

Check one Y=Yes	N=No	
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	
Y	N	1. Thalassemia	Y	N	8. Hemophilia or blood disorder
Y	N	2. Neural tube defect	Y	N	9. Muscular dystrophy
Y	N	3. Congenital heart defect	Y	N	10. Cystic fibrosis
Y	N	4. Down syndrome	Y	N	11. Huntington's chorea
Y	N	5. Tay-Sachs	Y	N	12. Mental handicap
Y	N	6. Canavan's disease	Y	N	13. Other chromosomal disorder
Y	N	7. Sickle cell disease or trait	Y	N	14. Other birth defect

Pregnancy Summary

_____ # of pregnancies
_____ # of full term
_____ # of premature

_____ # of miscarriages
_____ # of abortions
_____ # of ectopic/tubal

_____ # of twins/multiples
_____ # of living children

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

History of Pregnancy Complications

Check one Y=Yes	N=No	
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?