ADVANCED OBSTETRICS & GYNECOLOGY, LLC

"Comprehensive Healthcare for Women"

PREGNANCY QUESTIONNAIRE

PATIENT NAME: _____ DATE OF BIRTH: ____ / ____ / _____

1. *Will you be 35 or older when the baby is due?* ☐ YES ☐ NO

2. *Have you or any relatives had an abnormal delivery experience?* ☐ YES ☐ NO

3. *Have you or any relatives had a baby that suffered a complication of delivery?* ☐ YES ☐ NO

4. *Have you had a rash or fever since becoming pregnant?* ☐ YES ☐ NO

5. *Have you, the baby's father, or anyone in either of your families ever had any of the following disorders?*

- *a) Down Syndrome* ☐ YES ☐ NO
- *b) Chromosomal Abnormality* ☐ YES ☐ NO
- *c) Neural tube defect (spine defect, spina bifida, anencephaly)* ☐ YES ☐ NO
- *d) Heart defect* ☐ YES ☐ NO
- *e) Hemophilia* ☐ YES ☐ NO
- *f) Muscular Dystrophy* ☐ YES ☐ NO
- *g) Cystic Fibrosis* ☐ YES ☐ NO
- *h) Huntington Chorea* ☐ YES ☐ NO
- *i) Familial Dysautonomia* ☐ YES ☐ NO
- *j) Any inheritable disorder* ☐ YES ☐ NO
- *k) Mental retardation/Autism* ☐ YES ☐ NO

If you have answered YES to any disorder above, please list the affected family members:

_____

6. *Do you or the baby's father have a birth defect?* ☐ YES ☐ NO

7. *Have you or the baby's father had a child (dead or alive) with a birth defect not listed above?* ☐ YES ☐ NO

8. *Are there any family members with a birth defect?* ☐ YES ☐ NO

9. *Do you, the baby's father, or any family member have diabetes (abnormal blood sugar)?* ☐ YES ☐ NO

10. *Have you, the baby's father, or any relative had a stillbirth or recurrent miscarriage?* ☐ YES ☐ NO

11. *Are you or the baby's father Jewish or of French Canadian descent?* ☐ YES ☐ NO

12. *Are you or the baby's father of African American (black) descent?* ☐ YES ☐ NO

13. *Are you or the baby's father of Mediterranean descent? (Greek, Italian, etc.)* ☐ YES ☐ NO

14. *Are you or the baby's father of Philippine or Asian descent?* ☐ YES ☐ NO

15. *What medications have you taken since becoming pregnant?*

_____

16. *Have you been exposed to any chemicals or illnesses since becoming pregnant?* ☐ YES ☐ NO

17. *Did you have chicken pox in the past?* ☐ YES ☐ NO

18. *Do you have a cat?* ☐ YES ☐ NO

19. *Do you smoke cigarettes?* ☐ YES ☐ NO

20. *Do you use any drugs or drink alcohol?* ☐ YES ☐ NO

21. *Have you or any relatives had an abnormal reaction to any anesthesia medications?* ☐ YES ☐ NO

22. *List all medications that you are allergic to and the type of reaction:*

_____

23. *Have you ever been the victim of domestic abuse of any kind?* ☐ YES ☐ NO

24. *Have you ever been treated for a sexually transmitted disease?* ☐ YES ☐ NO

25. *Have you ever received care for any emotional/psychological problems?* ☐ YES ☐ NO

26. *Do you have any confidential issues you would like to discuss?* ☐ YES ☐ NO

27. *It is recommended that all pregnant women have an HIV (AIDS) test. Do you agree to have an HIV test?* ☐ YES ☐ NO

28. *Do you eat a healthy and well-balanced diet?* ☐ YES ☐ NO

29. *Do you exercise regularly?* ☐ YES ☐ NO

30. *Do you have a religious objection to blood products?* ☐ YES ☐ NO

31. *In a life-threatening emergency, will you accept a blood transfusion?* ☐ YES ☐ NO

32. *After the pregnancy, do you desire a permanent sterilization procedure?* ☐ YES ☐ NO

33. *Have you and/or the father of the baby recently traveled to an area of Zika transmission?* ☐ YES ☐ NO

34. *Do you and/or the father of the baby have any plans to travel to an area of Zika transmission?* ☐ YES ☐ NO

35. *LEAD SCREENING:*

a) *Have you ever eaten paint chips or plaster?* ☐ YES ☐ NO

b) *Do you live in a house built before 1978 with ongoing renovations that generate a lot of dust (for example, sanding and scraping)?* ☐ YES ☐ NO

c) *Do you use any traditional folk remedies or cosmetics that are not sold in a regular drug store or are homemade?* ☐ YES ☐ NO

d) *Do you use non-commercially prepared pottery or leaded crystal?* ☐ YES ☐ NO

e) *Do you have a history of previous lead exposure or live with someone identified with an elevated lead level?* ☐ YES ☐ NO

If you have answered YES to any of the lead screening questions above, please give additional details below:

_____

_____

_____ _____

Patient's Signature ***Physician's Signature***

_____ / _____ / _____ _____ / _____ / _____

Date ***Date***

PLEASE PROVIDE A DETAILED EXPLANATION AS NECESSARY FOR ANY ANSWERS ABOVE: