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Stanford MEDICINE | Partners

Pregnancy Questionnaire

Preferred Name: ______________________ Age: ___ Partner's name: ___________________________

Although we may have much of the information that we are asking for in this form, the initial visit for prenatal care is the most important time for both of us to thoroughly review your medical history and current health.

MENSTRUAL STATUS

First day of your Last Menstrual Period (LMP): _________ Are your cycles regular ☐ Yes ☐ No?
What is the typical interval in days? ________

MENTAL HEALTH HISTORY AND SCREENING

Have you ever been diagnosed or treated for anxiety? ☐ No ☐ Yes
Have you ever been diagnosed or treated for depression? ☐ No ☐ Yes
Have you been hit, kicked, punched, or otherwise hurt by someone in the past year? ☐ No ☐ Yes
Do you feel unsafe in your current relationship? ☐ No ☐ Yes
Is there a partner from a previous relationship who is making you feel unsafe now? ☐ No ☐ Yes

Over the past 2 weeks, how often have you been bothered by any of the following: *(Please x response)*

Patient Health Questionnaire (PHQ9)				
1. **Over the last 2 weeks, how often have you been bothered by any of the following problems?**	**Not at All**	**Several Days**	**More than Half the Days**	**Nearly Every Day**
a. Little interest or pleasure in doing things	☐	☐	☐	☐
b. Feeling down, depressed, or hopeless	☐	☐	☐	☐
c. Trouble falling/staying asleep, sleeping too much	☐	☐	☐	☐
d. Feeling tired or having little energy	☐	☐	☐	☐
e. Poor appetite or overeating	☐	☐	☐	☐
f. Feeling bad about yourself or that you are a failure or have let yourself or your family down	☐	☐	☐	☐
g. Trouble concentrating on things, such as reading the newspaper or watching television	☐	☐	☐	☐
h. Moving or speaking slowly that other people could have notice. Or the opposite; being so fidgety or restless that you have been moving round a lot more than usual	☐	☐	☐	☐
i. Thoughts that you are better off dead or hurting yourself in some way	☐	☐	☐	☐

Clinic use: GA_________ EDD_____________

2. If you checked off any problem on this questionnaire so far, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?	Not Difficult at all ☐	Somewhat Difficult ☐	Very Difficult ☐	Extremely Difficult ☐

Please check one:
Hispanic/Latino___; American Indian or Alaska Native___; Asian___; Black or African American___; Native Hawaiian or Other Pacific Islander___; White___

INFECTION HISTORY

Yes	No	
		Do you live with someone with TB or been exposed to TB?
		Do you have a history of Gonorrhea?
		Do you have a history of Chlamydia?
		Do you have a history of HPV (Human papilloma Virus)?
		Do you have a history of Syphilis?
		Do you have a history of Trichomonas?
		Do you have a history of HIV (Human Immunodeficiency Virus)?
		Do you have a history of Genital Herpes?
		Does your partner have a history of genital herpes?
		Have you had a skin rash or viral illness since your last period?
		Do you have a history of Hepatitis B or C?

Chicken Pox (Varicella) Status: ☐ Unknown ☐ Immunized ☐ Had disease ☐ Immune ☐ Negative

PRENATAL GENETIC SCREENING
PLEASE ANSWER ALL QUESTIONS:
Will you be 35 years or older when the baby is due? ☐ No ☐ Yes
Have you been previously tested for SMA, Fragile X, or Cystic Fibrosis? ☐ No ☐ Yes, result________________
Other carrier screening test results? ________________________________ (please provide copies of any results)
Do you have a Body Mass Index (BMI) of 30 or more? ☐ No ☐ Yes
Have you had three or more first trimester miscarriages? ☐ No ☐ Yes

Do you have any concerns you would like to discuss today?

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

	No	Yes	If yes, who?
Thalassemia			______________________
Neutral tube defect, Spina Bifida or Anencephaly?			______________________
Congenital Heart Defect?			______________________
Down Syndrome?			______________________
Tay-Sachs?			______________________
Canavan Disease?			______________________
Familial Dysautonomia?			______________________
Sickle cell disease or Trait?			______________________
Hemophilia or other blood Disorder?			______________________
Muscular Dystrophy?			______________________
Cystic Fibrosis?			______________________
Huntington's Chorea?			______________________
Autism or Mental Retardation?			______________________
Fragile X?			______________________
Any other Genetic or Chromosomal Disorder?			______________________
Have other children with birth defects?			______________________
Have any other birth defect not listed above?			______________________

PREVENTATIVE HISTORY

	No	Yes	Date (approx.)	
Have you had a flu shot this year?				
Did you receive the Covid-19 vaccine?				Which one?________

Date of last Pap smear: ____________________________

Date of last mammogram (over age 40 only):_________________________

MEDICATION ALLERGIES ❑ None

PLEASE WRITE ANY MEDICATION ALLERGY YOU HAVE HAD AND INCLUDE REACTION:

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DO YOU HAVE A NUT ALLERGY? ☐ No ☐ Yes, Reaction:_________________________

MEDICATIONS

Please list any prescribed medications you are taking or have taken since your last period: ☐ None

Medication Name	Dose/Strength	How do you take it?

Please list any non-prescribed or over the counter medications you are taking: ☐ None

MEDICAL HISTORY

PLEASE WRITE IN ANY MEDICAL CONDITIONS YOU HAVE OR HAVE HAD: ☐ None

Do you have diabetes, kidney disease, or an autoimmune disease? ☐ No ☐ Yes
Did you weigh less than 6 pounds at birth? ☐ No ☐ Yes ☐ Unsure

PLEASE WRITE IN ANY GYNECOLOGICAL CONDITIONS YOU HAVE OR HAVE HAD: ☐ None

Do you have an abnormality of your uterus? ☐ No ☐ Yes, what kind?________________________
Age you had your first period:_________

PLEASE WRITE IN ANY SURGERY YOU HAVE HAD (*PLEASE INCLUDE MONTH/YEAR*): ☐ None

SOCIAL HISTORY

Occupation? _________________________ Relationship status? (single, life partner, married) ______________

	No	Yes
Have you smoked since finding out you were pregnant?		
Is there passive smoke exposure (someone in the home environment that smokes)?		
Have you had alcoholic drinks since finding out you were pregnant?		
Have you used recreational drugs since finding out you were pregnant?		

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Do you currently use tobacco products? ___ No ___ Yes, are you ready to quit? ___No ___Yes

How often do you use:

Tobacco?	☐ Never	☐ Current/daily Type:________		☐ Former year quit: ________
E-Cigarette?	☐ Never	☐ Current/daily		☐ Former year quit: ________
Smokeless Tobacco?	☐ Never	☐ Current/daily		☐ Former year quit: ________
Alcohol?	☐ Never	☐ Current/daily	☐ Socially	☐ Former year quit: ________
Recreational Drugs?	☐ Never	☐ Current/daily Type: ________		☐ Former year quit: ________

FAMILY HISTORY

Please write list immediate family members (1st degree) who have:

Breast Cancer ______________________________ Colon Cancer _________________________________

Ovarian Cancer _____________________________ Other Cancer __________________________

Relationship	Name	Status/Age	List any/all Medical Conditions
Mother			
Father			
Sister			
Brother			
Maternal Grandmother			
Maternal Grandfather			
Paternal Grandmother			
Paternal Grandfather			
Other			
Other			

PREGNANCY HISTORY

How many times have you been pregnant? ____ How many children are living? ___ #twin pregnancies? ____

#Vaginal delivery ___ #Cesarean Section ___ #VBAC ___ #Miscarriage ___ #Abortion ___ #Ectopic _____

If you had a miscarriage or abortion, did you take pills or have a D&C procedure? __No __Yes, which________

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	No	Yes	
Was any pregnancy a second or third trimester loss?			
Did you deliver any pregnancy before the 37th week of gestation?			
Did you have an incompetent cervix with any pregnancy?			
Did you have high blood pressure or pre-eclampsia with any pregnancy?			
Did you have gestational diabetes with any pregnancy?			
Was any pregnancy delivered by C-section?			
Was any child less than 6 pounds or more than 10 pounds at birth?			
Do you have Rh-negative blood?			☐ Unsure

Delivery Details:

Date	Birth Weight	Vaginal or CS	#Weeks at birth	Gender	Delivery hospital	Baby's name(s)	Complications of pregnancy or delivery

Do you exercise? ☐ No ☐ Yes How often ________days/week for how long: ___________________

What type of exercise: ____

Are there cats in the home? ☐ No ☐ Yes, who changes the litter box? ____________________

Clinic Use Only: Height __________ Weight _________ BP _____________

Orders: ☐ Pap smear ☐ Mammogram ☐ DXA ☐ STI ☐ CT/GC ☐ Labs ☐ Immunization________ ☐ Referral

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