Prenatal Questionnaire

MENSTRUAL HISTORY
First day of your Last Menstrual Period (LMP): _____________ Was it normal in duration? □ Yes □ No
Do you have monthly periods? □ Yes □ No If no, how often do you have a period: ___________
At what age did you have your first period: ___________

CURRENT PREGNANCY
What is your height: ___________________ What is your weight pre-pregnancy: _______________
Were you using birth control prior to finding out you were pregnant? □ No □ Yes If yes, type: ___________
Will you be 35 years or older at the time of delivery? □ No □ Yes Your Ethnicity: ___________________
Baby’s Father Name: ___________________ FOB Ethnicity: ___________________
Do you consider this pregnancy to be high risk? □ No □ Yes If yes, why? __________________________
Did you conceive by IVF or ART procedures? □ No □ Yes If yes, what procedure: ____________________
If yes, what procedure: __________________________
Have you used any hot tubs, saunas, or steam bath since you found out you were pregnant? □ No □ Yes
Do you have a pediatrician? □ No □ Yes If yes, who? ________________________________
What medications have you taken since your last menstrual period: ______________________________
Do you desire sterilization at the time of delivery? □ No □ Yes
Are you enrolled or plan to enroll in WIC Prenatal Care Program? □ No □ Yes

PAST PREGNANCY HISTORY

<table>
<thead>
<tr>
<th>TOTAL PREGNANCIES</th>
<th>FULL TERM</th>
<th>PREMATURE</th>
<th>ABORTIONS INDUCED</th>
<th>ABORTIONS SPONTANEOUS</th>
<th>ECTOPICS</th>
<th>MULTIPLE BIRTHS</th>
<th>LIVING</th>
</tr>
</thead>
</table>

PAST PREGNANCY (LAST SIX)

<table>
<thead>
<tr>
<th>DATE M/D/Y</th>
<th>GA WEEKS</th>
<th>LENGTH OF LABOR</th>
<th>BIRTH WEIGHT</th>
<th>SEX</th>
<th>TYPE OF DELIVERY</th>
<th>PLACE OF DELIVERY</th>
<th>COMPLICATIONS</th>
</tr>
</thead>
</table>

Was any pregnancy a second or third trimester loss? □ No □ Yes
Did you deliver any pregnancy prior to 37 week’s gestation? □ No □ Yes
Did you have an incompetent cervix with any pregnancy? □ No □ Yes
Did you have high blood pressure or pre-eclampsia with any pregnancy? □ No □ Yes
Did you have gestational diabetes with any pregnancy? □ No □ Yes
Was any pregnancy delivered by C-section? □ No □ Yes
Are you Rh Negative? □ No □ Yes □ Unsure
Today’s Date: __/___/____ Your name: ____________________________________________ Date of Birth: ___/___/____

MEDICAL HISTORY (CHECK ALL THAT APPLY)

☐ DIABETES ☐ AUTOIMMUNE DISORDER ☐ D (RH) SENSITIZED
☐ KIDNEY DISEASE ☐ HEART DISEASE ☐ TUBERCULOSIS
☐ NEUROLOGIC/EPILEPSY ☐ THYROID DYSFUNCTION ☐ DRUG ALLERGIES
☐ PSYCHIATRIC ☐ ASTHMA ☐ LATEX ALLERGY
☐ DEPRESSION ☐ POST PARTUM DEPRESSION ☐ BREAST IMPLANTS
☐ HEPATITIS ☐ LIVER DISEASE ☐ GYN SURGERY
☐ VARICOSITIES ☐ PHLEBITIS ☐ HISTORY OF ABNORMAL PAP
☐ SEASONAL ALLERGIES ☐ ANESTHETIC COMPLICATIONS ☐ UTERINE ANOMALY
☐ HISTORY OF BLOOD TRANSFUSIONS ☐ INFERTILITY
OTHER NOT LISTED ABOVE:

SURGICAL HISTORY

SURGERY PERFORMED MONTH/YEAR SURGERY PERFORMED MONTH/YEAR
☐ ABDOMINAL SUTGERY ______________________ ☐ MYOMECTOMY ______________________
☐ APPENDECTOMY ______________________ ☐ LAPAROSCOPY ______________________
☐ C-SECTION ______________________ ☐ LEEP/CONE BIOPSY ______________________
☐ GASTRIC BYPASS ______________________ ☐ OTHER: ______________________
☐ OTHER: ______________________

DRUG ALLERGIES

ARE YOU ALLERGIC TO LATEX? ☐ Yes ☐ No

<table>
<thead>
<tr>
<th>MEDICATION</th>
<th>REACTION</th>
<th>MEDICATION</th>
<th>REACTION</th>
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FAMILY HISTORY

Please write any diseases/conditions present in your family:

Mother: _____________________________________________ ☐ Deceased

Father: _____________________________________________ ☐ Deceased

Sister: _____________________________________________ ☐ Deceased

Sister: _____________________________________________ ☐ Deceased

Brother: _____________________________________________ ☐ Deceased

Brother: _____________________________________________ ☐ Deceased

Other family members (name relationship and medical disease/condition)

________________________________________________________________________
GENETIC SCREENING

Do you, the baby's father, or a member of either family, been diagnosed with any of the following:

<table>
<thead>
<tr>
<th>NO</th>
<th>IF YES, WHO</th>
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<tbody>
<tr>
<td>☐</td>
<td>THALASSEMIA?</td>
</tr>
<tr>
<td>☐</td>
<td>NEUTRAL TUBE DEFECT (MENINGOMYELOCELE, SPINA BIFIDA OR ANACEPHALY)?</td>
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<tr>
<td>☐</td>
<td>CONGENITAL HEART DEFECT?</td>
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<td>☐</td>
<td>DOWN SYNDROME?</td>
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<tr>
<td>☐</td>
<td>TAY-SACHS</td>
</tr>
<tr>
<td>☐</td>
<td>CANAVAN DISEASE?</td>
</tr>
<tr>
<td>☐</td>
<td>FAMILIAL DYSAUTONOMIA?</td>
</tr>
<tr>
<td>☐</td>
<td>SICKLE CELL DISEASE OR TRAIT?</td>
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<tr>
<td>☐</td>
<td>HEMOPHILIA OR OTHER BLOOD DISORDERS?</td>
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<tr>
<td>☐</td>
<td>MUSCULAR DYSTROPHY?</td>
</tr>
<tr>
<td>☐</td>
<td>CYSTIC FIBROSIS?</td>
</tr>
<tr>
<td>☐</td>
<td>HUNTINGTON'S CHOREA?</td>
</tr>
<tr>
<td>☐</td>
<td>MENTAL RETARDATION / AUTISM?</td>
</tr>
<tr>
<td>☐</td>
<td>FRAGILE X</td>
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<tr>
<td>☐</td>
<td>OTHER INHERITED GENETIC OR CHROMOSOMAL DISORDER?</td>
</tr>
<tr>
<td>☐</td>
<td>OTHER BIRTH DEFECT NOT LISTED ABOVE?</td>
</tr>
</tbody>
</table>

INFECTION HISTORY

Yes  No  Have you had the chicken pox or the vaccination?
Yes  No  Do you live with someone with TB or been exposed to TB?
Yes  No  Have you had a Rash or viral illness since your last period?
Yes  No  Do you have a history of Hepatitis B or C?
Yes  No  Do you have a history of HPV (Human papilloma Virus)?
Yes  No  Do you have a history of HIV (Human Immunodeficiency Virus)?
Yes  No  Do you have a history of STI (Sexual Transmitted Infection)?
Yes  No  Do you have a history of Genital Herpes?
Yes  No  Do you have a history of Gonorrhea?
Yes  No  Do you have a history of Chlamydia?
Yes  No  Do you have a history of Syphilis?
Yes  No  Does your partner have a history of genital herpes?

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

<table>
<thead>
<tr>
<th>1. little interest or pleasure in doing things</th>
<th>Not at all</th>
<th>Several days</th>
<th>More than ½ the days</th>
<th>Nearly every day</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
</tbody>
</table>

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<tr>
<th>2. feeling down, depressed or hopeless</th>
<th>Not at all</th>
<th>Several days</th>
<th>More than ½ the days</th>
<th>Nearly every day</th>
</tr>
</thead>
<tbody>
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<td>1</td>
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<td>3</td>
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</table>
SOCIAL HISTORY

Do you use Tobacco? □ Never □ Current □ Former  
Type: □ Cigarettes □ E-Cigarettes

How many pack of cigarettes each day ___________ Number of years smoked? ___________

Do you use smokeless tobacco?: □ No □ Yes

Have you smoked since finding out you were pregnant? □ No □ Yes

Is there passive smoke exposure? □ No □ Yes

Do you drink Alcohol? □ Never □ Daily □ Socially  
Drinks per week______________

Have you drank alcohol since finding out you were pregnant? □ No □ Yes

Do you use Recreational Drugs? □ No □ Yes

If yes, which type? □ Methamphetamine □ Ecstasy □ Heroin □ Cocaine IV □ Prescription Drugs

Have you used recreational drugs since finding out you were pregnant? □ No □ Yes

Do you exercise? □ No □ Yes  
How often ________days/week  for how long: ______________

What type of exercise: ________________________________________________________________

Has your current partner ever threaten you or made you feel afraid? □ No □ Yes

Has your current partner ever hit, choked or physically hurt you? □ No □ Yes

Are there cats in the home? □ No □ Yes  
If yes, who changes the litter box? ______________

Do you wear your seatbelt frequently? □ No □ Yes

Are there firearms in the home? □ No □ Yes

Are there smoke detectors in the home? □ No □ Yes

Are there carbon monoxide detectors in the home? □ No □ Yes

--------------------------------------------------------Clinic Use Only-----------------------------------------------------------

Weight ______________  MD order □ PN Labs
Blood Pressure ______/________
EDD by LMP ____________________  U/S EDD ______________

F: EPIC/Patient forms/ pregnancy confirmation v_12_3_18