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Please complete and bring this questionnaire with you to your first prenatal visit.

MEDICAL ALLERGIES

Which drugs or medicines are you allergic or sensitive to?

Drug	Reaction

PATIENT INFORMATION

Name: _____

Address: _____

Phone: Day (____) ____ - ____ Evening (____) ____ - ____ Cell (____) ____ - ____

Age: ____ Date of Birth: _____

Marital Status: Married Single Widowed Divorced Separated

Ethnic Group/Race: _____ Religion: _____

Occupation: _____ Yrs of Education: _____

Emergency Contact: _____ Relationship: _____ Phone: (____) ____ - ____

SPOUSE/SIGNIFICANT OTHER INFORMATION

Name of Spouse/Significant Other: _____

Is this the father of your baby? Yes No Age: _____

Phone numbers: Day (____) ____ - ____ Evening (____) ____ - ____ Cell (____) ____ - ____

Ethnic Group/Race: _____ Religion: _____

Occupation: _____ Yrs of Education: _____

MENSTRUAL HISTORY/DATING INFORMATION

Date of the first day of your last period: _____ Definite Approximate Unknown

Was your period normal in number of days of flow? Yes No

Normal cycle length: _____ days

Date of conception, if known: _____

Where you on birth control pills/Depo shots when your last period started? Yes No

If so, when did you last take them/it: _____

Were you breastfeeding when your last period started? Yes No Date stopped: _____

Have you had a positive pregnancy test? Yes No Date: _____

If yes, was it done at: home clinic

PREVIOUS PREGNANCIES (List all previous pregnancies, include miscarriages or abortions):

	Month & Year	Vaginal delivery, cesarean, miscarriage or abortion?	Gestational age (wks at delivery)	Hours in labor	Baby's birth weight	Baby's name & sex	Epidural?	Name of hospital
1								
2								
3								
4								
5								
6								

Problems during pregnancy? _____

Problems with labor or in postpartum? _____

Any gestational diabetes during your pregnancies? Yes No

If yes, explain: _____

PAST MEDICAL/SURGICAL HISTORY

Have you ever had (If yes, please explain and note date):

YES NO

Diabetes (high blood sugar)?

Hypertension (high blood pressure)?

Heart disease/congenital heart disease/defects, mitral valve prolapse or rheumatic fever?

Autoimmune disease such as lupus or rheumatoid arthritis?

YES

NO

Kidney disease, kidney infection, urinary tract or many bladder infections?

Migraine headaches, Strokes or seizures?

Any other neurological problems?

Have you ever required psychiatric care?

Have you ever had hepatitis, liver disease or jaundice?

Have you ever had varicose veins or hemorrhoids?

Have you ever been treated for blood clots in your veins, deep venous thrombosis, inflammation in the veins, thrombosis, phlebitis or pulmonary embolism?
If yes, please state which and when: _____

Have you had excessive bleeding after surgery or dental work?

Do you bleed more than other women do after a cut or a scratch?

Do you have a history of anemia?

Have you ever had a thyroid problems or taken thyroid medications?

In the last year, has anyone forced you to have sex when you did not want to?
If yes, who? _____

In the last year, has anyone hit, slapped, kicked or otherwise hurt you?
If yes, who? _____

Have you ever been in a major accident or suffered serious injuries or broken bones?

- YES** **NO**
- Have your ever received a blood transfusion?

- Do you have a religious or other reason you would refuse a "life-saving" blood transfusion?

- Have you ever developed abnormal antibodies in your blood?
If yes, has this caused a problem with a previous pregnancy & if so pls explain? _____
- Have you ever had asthma or tuberculosis?

ALCOHOL/TOBACCO/DRUGS

Have you ever used any of the following:

- YES** **NO**
- Tobacco/Cigarettes? If yes, how much and when: _____
- Alcohol, beer, wine? If yes, how much and when: _____
- Street drugs? If yes, which ones, how much and when: _____
- Does anyone in your household smoke? If yes, who: _____
- Does your partner abuse alcohol or drugs?

GYN HISTORY

Have you ever had any gynecological surgical procedure such as:

- YES** **NO**
- Cervical Conization If yes, when and where: _____
- Leep Procedure If yes, when and where: _____
- Laser treatment If yes, when and where: _____
- Cryosurgery of the cervix If yes, when and where: _____
- Dilation and curettage (D&C) If yes, when and where: _____
- Have you ever had any other surgical procedures? _____
- Have you ever had any breast problems? _____
- Have our ever had any problems with breastfeeding? _____
- Have you ever been hospitalized for a non-surgical reason other than a normal delivery? _____
- Have you ever had any complications or problems from anesthesia? _____
- Have you ever had an abnormal PAP smear? _____
- Do you or anyone in your family have a history of an abnormal uterus? _____

- | YES | NO | |
|--------------------------|--------------------------|--|
| <input type="checkbox"/> | <input type="checkbox"/> | Did your mother take DES or any other hormones when she was pregnant with you to prevent miscarriage? _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Did it take more than one year to become pregnant? _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Have you ever been evaluated or treated for infertility? _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Is there a history of medical problems in your family that you feel might adversely affect your health or this pregnancy? _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Do you have any other problem we have not asked about which you feel might be of importance to this pregnancy? If yes, what? _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Have you had any symptoms or problems since your last menstrual period?
_____ |

GENETIC HISTORY

Will you be age 35 or older at delivery? yes no

Have you had three or more miscarriages or a prior stillbirth? yes no

Used any medications, alcohol or drugs since your pregnancy? yes no

Is your blood type Rh negative? yes no not sure

Are you or the baby's father of Mediterranean ancestry? yes no

If yes, has either of you been screened for Thalassemia? yes no

If yes, please indicate who was screened and the results: _____

Are you or the father of the baby of Jewish, Cajun or French Canadian descent? yes no

If yes, has either of you been screened for Tay-Sachs and/or Canavan's disease? yes no

If yes, indicate who was screened and the results: _____

Are you or the father of the baby of African American ancestry? yes no

If yes, has either of you been screened for sickle cell disease or trait? yes no

If yes, indicated who was screened and the results: _____

Have you, the baby's father or anyone in either family had one of the following? If yes, please indicate who:

YES **NO**

- | | | |
|--------------------------|--------------------------|--|
| <input type="checkbox"/> | <input type="checkbox"/> | Brain, spinal cord or neural tube defects, meningomyelocel (open spine), spina bifida or anencephaly?
_____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Congenital heart disease/defect? _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Down Syndrome? _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Hemophilia (blood that does not clot well) or any other inherited blood clotting disease? _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Muscular Dystrophy, Huntington's Chorea, or Cystic Fibrosis: _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Mental retardation or autism? _____
If YES, was the person tested for fragile X? _____ |

YES NO

Other inherited genetic or chromosomal disorders? Please identify: _____

Insulin dependent diabetes, phenylketonuria or any other metabolic disorder? _____

A prior child with a birth defect not listed above?

INFECTION HISTORY

YES NO

Have you ever received BCG (a shot to prevent TB—not given routinely in the US)?

Have you ever had a positive skin test for Tuberculosis (TB)?

Do you live with someone who has had TB?

Have you been otherwise exposed to TB?

Do you have genital herpes?

Does your partner have genital herpes?

Have you had a rash or a viral illness since your last period?

Have you ever had gonorrhea, Chlamydia, Syphilis, Trichomoniasis, or any other STD's?

If known, are you a Group B Streptococcus carrier?

Have you ever had chickenpox/varicella?

Have you ever been vaccinated against chickenpox?

Have you ever had any other infectious diseases that could affect this pregnancy?

Do you have any cats at home?