Prenatal Questionnaire

NAME:_____ **Date of Birth**_____

Do you have any allergies? If so what is the reaction you experience?:

Current Medications: Dose/route/frequency (include prescriptions, vitamins and over the counter medications)

Preferred Pharmacy:(Name, Street, City, State)

Height:_____ **Weight prior to pregnancy**:_____

Medical History:

	YES	NO		YES	NO		YES	NO
Abnormal Pap			Diabetes			Infertility		
Anemia			Endometriosis			IBS		
Anxiety			Gall bladder disease			Multiple Sclerosis		
Asthma			Gestational Diabetes			Seizures		
Blood clotting disorder			Headaches			STDs		
Blood transfusion			Hemorrhoids			Toxoplasmosis		
Breast problems			Herpes			Tuberculosis		
Coronary Artery Disease			Hypertension			Uterine abnormalities		
Crohn's Disease			Hyperthyroid			UTI		
Depression			Hypothyroid			Varicella/Chicken pox		

Other:

Surgical History

	YES	NO		YES	NO
Appendectomy			Cryosurgery of cervix		
Breast biopsy			D&C		
Breast enhancement			Hysterectomy		
Breast Reduction			Hysteroscopy		
C-Section			Laser ablation of cervix		
Cholecystectomy			Leep		
Colposcopy			Pelvic laparoscopy		
Conization of cervix			Tubal ligation		

Other:

Family Medical History

	Status (alive/deceased)	Alcohol Abuse	Alzheimer's	Bipolar disorder	Breast cancer	Colon Cancer	Heart disease	Depression	Early menopause	Gall bladder disease	High cholesterol	Hypertension	Hyperthyroid	Hypothyroid	Melanoma	Migraines	Osteoporosis	Ovarian Cancer	Stroke	Uterine Cancer
Mother																				
Father																				
Brother																				
Sister																				
MGM																				
MGF																				
PGM																				
PGF																				

Other:_____

SOCIAL HISTORY:

Have you ever smoked? ❑Yes ❑No ❑Current smoker ❑Quit (month/year):_____
If yes, how many packs per day? ❑<1 ❑1 ❑2 ❑>3
For how many years?_____

Do you drink alcohol? ❑Yes ❑No ❑Not currently
If yes, how many drinks per week? ❑<1 ❑1-4 ❑5-10 ❑>20

Have you ever used recreational drugs, including prescription drugs? ❑Yes ❑No
If yes, what drug(s)_____

Are you sexually active?_____
Type of partner ❑ Male ❑ Female ❑ Both
Number of partners _____

Method of birth control prior to pregnancy:_____

PSYCHOSOCIAL HISTORY

Who lives at home with you?_____

Highest level of education:
❑Elementary ❑Junior High ❑High School ❑College ❑Graduate School

What is your occupation?_____

Relationship status:
❑Single ❑Partnered/Married ❑Divorced ❑Widowed ❑Other

If you have a domestic partner/spouse, what is his or her name?_____

If you have a partner, has he or she ever hit you, kicked you or threatened to harm you?
❑Yes ❑No

OBSTETRIC HISTORY:

Pregnancies: _____ # Deliveries: _____ # Abortions: _____ # Miscarriages: _____ # Ectopic Pregnancies: _____

Pregnancies: (outcome is vaginal delivery, cesarean, miscarriage, termination or ectopic)

	Date	Outcome	# of weeks	Is baby living	Hours in Labor	Weight of Baby	Sex	Name of Baby	Hospital	M.D.	Epidural
1											
2											
3											
4											
5											

Did you have pre-term labor with any of your prior pregnancies?
❑Yes ❑No
Did you have any complications during any of your previous pregnancies? *Diabetes, hypertension, anemia, preterm delivery. Please specify*
❑Yes ❑No
Did you have any complications during your previous deliveries? *Excessive bleeding, shoulder dystocia, please specify*
❑Yes ❑No
Did any of your babies weigh more than 9 lbs or less than 5.5 lbs?
❑Yes ❑No
Did your baby require stay in the Neonatal Intensive Care Unit?
❑Yes ❑No
Did you breastfeed with your other babies? If so, for how long?
❑Yes ❑No

MENSTRUAL HISTORY:

First day of most recent period: (**LMP**) _____ Are your periods regular? ❑ Yes ❑ No
Age at onset of menses: _____ Length of Cycles:_____ days (start to start)
Days of bleeding:_____
Flow:❑Light ❑Medium ❑Heavy Painful cramps?❑Yes ❑No

CURRENT PREGNANCY

Did you have fertility treatment with this pregnancy?❑Yes ❑No
If so what type?_____
Is this pregnancy a result of donor egg or donor sperm?_____
Age of egg donor:_____
If you took fertility medications, which one(s) did you take?_____

Do you plan on breast feeding? ❑Yes ❑No

Are you experiencing any of the following?

- Nausea or vomiting ❑Yes ❑No
  If you are throwing up, on average how many times a day?
- Vaginal bleeding ❑Yes ❑No
- Cramping ❑Yes ❑No
- Constipation ❑Yes ❑No

INFECTION SCREENING:

Do you live with someone with TB or have you been exposed to TB?
❒Yes ❒No ❒Don't Know
Do you or your partner have genital herpes?
❒Yes ❒No ❒Don't Know
Have you had Gonorrhea, Chlamydia, HPV, Syphilis or Trichomoniasis?
❒Yes ❒No ❒Don't Know
Have you had the chicken pox or the vaccine?
❒Yes ❒No ❒Don't Know
Do you have cats?
❒Yes ❒No

HEALTH CARE MAINTENANCE

Last Pap smear (month/year): _____ ❑ Normal ❑ Abnormal

Did you have a flu shot this flu season? (September-March) ❒Yes ❒No

Have you received the COVID vaccine and boosters? ❒Yes ❒No

PRENATAL GENETIC SCREENING:

Have you had carrier screening either in a past pregnancy or prior to conception?
❑Yes ❑No

Mother of Baby or EGG DONOR ancestry:
❑ Caucasian/Northern European descent ❑African American ❑Jewish
❑Italian, Greek, Middle Eastern ❑Asian ❑Hispanic ❑Filipino ❑Other_____

Father of Baby or SPERM DONOR ancestry:
❑ Caucasian/Northern European descent ❑African American ❑Jewish
❑Italian, Greek, Middle Eastern ❑Asian ❑Hispanic ❑Filipino ❑Other _____

Will you be 35 years old or older when the baby is due? _____

Do you, the baby's father or anyone in either family have any one of the following disorders:

- Thalassemia…….. ❑Yes ❑No
- Neural Tube Defects, Spina Bifada, Anencephaly ..... ❑Yes ❑No
- Congenital Heart Defect ..... ❑Yes ❑No
- Down Syndrome .....❑Yes ❑No
- Tay-Sachs..... ❑Yes ❑No
- Sickle Cell Disease or Trait ..... ❑Yes ❑No
- Hemophilia or Blood Disorder .....❑Yes ❑No
- Muscular Dystrophy .....❑Yes ❑No
- Cystic Fibrosis .....❑Yes ❑No
- Intellectual disabilities/Autism.....❑Yes ❑No
- Spinal Muscular Atrophy…….....❑Yes ❑No
- Any other Genetic or Chromosomal Disorder ..... ❑Yes ❑No

Do you, the baby's father or a close family member have a birth defect or a chromosomal abnormality not listed above? ❒Yes ❒No ❒Don't Know

Are you and the father of the baby blood relatives? ❒Yes ❒No

If you answered yes to any of the above questions, please indicate the condition and the relationship of the affected person to you or the baby's father:

Print Name_____ Date of Birth_____
Signature_____ Date_____