Name:____________________________________

Date of Birth:______________________________

Appointment Date:__________________________

Prenatal History Questionnaire

PART 1

- When was your last menstrual period? ____

- Do you have any allergies? (such as medications, environmental, latex, or other allergens?)
  Please list allergen and reaction.
  - ____
  - ____
  - ____
  - ____
  - ____

- Do you currently have any medical issues? (For example, but not limited to: high blood pressure, heart problems, diabetes, an under/over active thyroid?) If no, please proceed to next question.

  If yes, please list medical problem, the doctor that treats you and any medication prescribed.

  - ____
  - ____
  - ____
  - ____
  - ____
  - ____

- Have you recently been treated with any short-term medication? If no, please proceed to next question.
  If yes, please list problem that required medication the medication that was prescribed and the length of time you took medication.
  - ____
  - ____
  - ____
  - ____

- Have you ever had surgery? If no, please proceed to next question.
  If yes, **please list surgical procedure, date of procedure, facility it was done at, and physician who performed procedure**.
  - ____
  - ____
  - ____
  - ____
  - ____

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- Are you currently being treated for (or have a history of) depression, anxiety, bi-polar, or other mental illness? If no, please proceed to next question.
  If yes, please list <u>physician who follows you and what medication you are currently taking</u>.
  - ____
  - ____
  - ____
  - ____

- Do you have a history of alcohol use, recreational drug use or drug dependency? If yes, please list what drugs you have recently used or are currently using:
  ____
  - If yes, do you take medication (such as Methadone, Suboxone, or Subutex) to help with this (list med and prescribing MD)? ____
  - Have you ever been screened for Hepatitis C (if positive drug history)?
    ____

- Do you currently smoke cigarettes or use tobacco products?
  - If yes, how many packs per day do you smoke? ___________________________________

- In the case of an emergency or life-threatening situation, **would you permit a blood transfusion (**receiving donor blood due to losing too much blood after delivery and/or surgery)?

  YES_________ NO_________

  If you would **<u>NOT</u>** permit a blood transfusion due to religious beliefs, do you have documents regarding this? Please provide a copy for your chart.

- **Current medications** (includes OTC/supplements/prescriptions…even prenatal vitamins!)
  - ____
  - ____
  - ____
  - ____
  - ____

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Genetic History

Do you **or your significant other** have a personal or family history of any of the following? Check all that apply:

_____Thalassemia (Italian, Greek, Mediterranean, or Asian background)

_____Neural Tube Defect (Spina bifida or Spina bifida occulta, anencephaly)

_____ Cleft lip and/or cleft palate

_____ Clubbing of one or both feet

_____Heart defect that may or may not have required surgery

_____Down Syndrome

_____Tay-Sachs (Jewish, Cajun, or French-Canadian)

_____ Canavan disease

_____ Huntington's Chorea

_____Sickle cell disease

_____Hemophilia (bleeding disorder)

_____Stroke or sudden, unexpected death at an early age

_____Muscular Dystrophy

_____ Cystic Fibrosis

_____Mental retardation/Autism/Fragile X

_____Recurrent pregnancy loss/fetal demise/neonatal death

_____ Any other inherited genetic syndromes or chromosomal disorders?

If you indicated a family history on either your side or your significant other's side, please list family member relation and also indicate whose side:

____

____

____

____

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Family Medical History

(This only pertains to patient, not significant other. Please indicate with: **F**- father, **M**-mother, **PA**- paternal aunt, **MA**- maternal aunt, **MC-** maternal cousin, **PC-**paternal cousin, **PGF**- paternal grandfather, **MGF**- maternal grandfather, **MGM**-maternal grandmother, **PGF**-paternal grandfather, **S**-sister, **B**-brother, **1/2S**- half-sister, **1/2B**- half-brother. Please note, half siblings share either the same mother or same father. They are not the same as step siblings. Step siblings are not blood related).

_________ Arthritis

_________ Autoimmune disease such as lupus, Sjogren's, rheumatoid arthritis

_________ Cancer, please indicate what type of cancer ____

_________ Diabetes

_________ Heart disease

_________ Hypertension

_________ Stroke

_________ Sudden cardiac event that resulted in death, prior to age 50.

Infection History

- Have either you or your significant other ever been exposed to or treated for tuberculosis in the past?
  ______ yes   _______ no

- Have either you or your significant other ever been diagnosed with genital herpes or have ever had an outbreak of genital lesions? _____yes _____no

- Have you had a rash or viral illness since your last menstrual period? _____yes _____no

- In the past (or recently), have you ever been diagnosed with:
  - ______ Gonorrhea
  - ______Chlamydia
  - ______Syphilis
  - ______Herpes (genital or oral)
  - ______ HPV (human papilloma virus)

  Were you and your partner both treated? _________________________

- Have you or your partner ever been diagnosed with Hepatitis B, Hepatitis C, or HIV?

  - If yes, please indicate when diagnosis occurred and any relevant treatment:
    ____

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- Have you been to a "Zika Virus" area such as Mexico, the Caribbean, Indonesia, Middle East, Africa, South American or other areas as identified by the CDC? ______yes ______no

- If yes, did you notice any mosquito bites or experience a fever, rash, or joint pain? ______ yes ______no

- Have you had intercourse with someone who has recently travelled to a Zika Virus area? _______yes ______no

- Have you had intercourse with someone who has been diagnosed with the Zika Virus in the last 6 months?

  ______ yes _____no

PART 2 (Only complete if you have been pregnant in the past)

- How many times have you been pregnant, **NOT** including this pregnancy? ___________

- Have you ever had a miscarriage?_________________________

- Did you require a D&C (surgical procedure done after miscarriage to remove contents of uterus that did not pass on its own)? ____________________________

- Have you ever terminated a pregnancy (had an abortion)? ______________________

- Did you have any complications after abortion?_______________________________

- Have you ever had a pregnancy loss or stillbirth **AFTER** 12 weeks?
  - Please provide any relevant information regarding loss after 12 weeks:____
    ____

- Did you have any problems during your previous pregnancies such as hypertension, gestational diabetes, seizure disorder, hyper/hypothyroid that required medication management or frequent lab work?

  ____

  ____

  ____

- Are your children healthy or do they have any long-term problems that require ongoing medical management?

  ____

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Please complete table to provide us with information pertaining to ALL past pregnancies/deliveries (including miscarriages/terminations).

Date of birth	Male or Female	Weight	Gestation	Vaginal or C-section	Doctor	Place of birth	Complications

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If you do not have adequate room in table to share all relevant information, feel free to use the space below and please feel free to include any other information that you would like to share with us:

Thank you! We look forward to seeing you soon ☺

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