Patient Name: _____

Date of Birth: _____

New Pregnancy Questionnaire

Please allow 20-30 minutes to complete this questionnaire prior to your first prenatal appointment.

What was the date of your last menstrual period?	

About

Height *	ft in
Pre-pregnancy Weight	lb
What is your occupation?	
Is English your native language?	**No** **Yes**
What is the name of your partner/spouse?	
What is the phone number of your partner/spouse?	
Is the father of the baby 40 or older?*	**No** **Yes**

Sensitive

Has your current partner ever threatened you, or made you feel afraid?*	**No** **Yes**
Have you ever been in an abusive relationship?*	**No** **Yes**
Do you feel unsafe in the neighborhood where you live?*	**No** **Yes**

Pregnancy History

Is this your first pregnancy?*	**No** **Yes**
Have you ever had a C-Section?	**No** **Yes**
Do you feel like you had a really stressful experience with any labor and delivery from any previous pregnancy?	**No** **Yes**
Did you have a forceps assisted delivery in any previous pregnancy?	**No** **Yes**
Did you ever have Vacuum Extraction delivery assistance on a previous pregnancy?	**No** **Yes**

Did you deliver a larger than normal infant (baby greater 8lbs,13oz) on a previous pregnancy?	**No**	**Yes**
Have you ever lost a pregnancy after 14 weeks gestation?	**No**	**Yes**
Have you ever had your uterus rupture during pregnancy, labor, or delivery?	**No**	**Yes**
Have you ever had a placental abruption or placental separation?	**No**	**Yes**
Have any of your babies been infected with Group B Strep?	**No**	**Yes**
Have you ever had a baby who was too small or growth restricted?	**No**	**Yes**
Have you had Gestational Diabetes with a previous pregnancy?	**No**	**Yes**
Have you been diagnosed with high blood pressure/preeclampsia gestational hypertension or HELLP syndrome in your previous pregnancies?	**No**	**Yes**
Were you ever admitted with pre-term contractions or diagnosed with pre-term labor in a previous pregnancy?	**No**	**Yes**
Have you had a preterm delivery at less than 37 weeks?	**No**	**Yes**
Have you ever been diagnosed with a shortened cervix in a previous pregnancy?	**No**	**Yes**
During a previous delivery, did the baby's shoulder get stuck on the way out?	**No**	**Yes**
Have you ever had a hemorrhage after delivery with a previous pregnancy?	**No**	**Yes**
Have you had postpartum depression?	**No**	**Yes**
Were you ever re-admitted to the hospital after a delivery?	**No**	**Yes**
Did you have complications during a previous pregnancy or postpartum other than those listed above?	**No**	**Yes**

Endocrine History

Do you have an overactive thyroid, or Graves disease?	**No**	**Yes**
Do you have an underactive thyroid, or Hashimoto's thyroiditis?	**No**	**Yes**
Do you have insulin-dependent or juvenile (Type 1) diabetes?*	**No**	**Yes**
Do you have adult-onset (Type 2) diabetes?*	**No**	**Yes**

Do you have Polycystic Ovarian Syndrome (PCOS)	**No**	**Yes**

Cardiovascular History

Do you have high blood pressure?*	**No**	**Yes**
Do you have ITP, history of low platelet count, or a platelet disorder?*	**No**	**Yes**
Have you ever had a blood clot in the leg (DVT) or lung (Pulmonary Embolism) or a disorder that makes your blood clot more than usual?*	**No**	**Yes**
Do you have any cardiovascular problems (heart/heart valve disease, previous heart surgery, heart defects, aortic aneurysm, arrhythmia, rapid or irregular heartbeat, or postpartum heart failure)	**No**	**Yes**

Neurological History

Do you have any type of seizure disorder?	**No**	**Yes**
Have you ever been diagnosed with a stroke (CVA, TIA)?	**No**	**Yes**
Have you ever been diagnosed with migraines?	**No**	**Yes**

Psychiatric History

Do you have problems with anxiety?*	**No**	**Yes**
Have you had a problem with depression?*	**No**	**Yes**
Have you ever been diagnosed with PTSD?	**No**	**Yes**
Have you ever been diagnosed with OCD?	**No**	**Yes**
Have you been diagnosed with a bipolar (manic-depressive) disorder?	**No**	**Yes**
Do you have schizophrenia?	**No**	**Yes**
Have you ever attempted suicide?	**No**	**Yes**
Have you ever been diagnosed with ADD (Attention Deficit Disorder) or ADHD (Attention Deficit Hyperactivity Disorder)?	**No**	**Yes**

Respiratory History

Do you currently have asthma?*	**In Past**	**No**	**Yes**
Do you have any pulmonary disease or lung problems other than asthma?		**No**	**Yes**

Surgical History

Have you ever had any complications with anesthesia?	**No**	**Yes**
Have you ever had postoperative complications?	**No**	**Yes**
Have you had weight loss/bariatric surgery?*	**No**	**Yes**
Have you ever had a blood transfusion?*	**No**	**Yes**
Have you ever had back surgery?	**No**	**Yes**
Have you ever had abdominal surgery (including c-section)?*	**No**	**Yes**
Have you ever had cosmetic surgery (including breast augmentation, tummy tuck)?	**No**	**Yes**
Have you ever had transplant surgery	**No**	**Yes**

Gastroenterological History

Do you have Ulcerative Colitis?	**No**	**Yes**
Do you have Crohn's disease?	**No**	**Yes**
Do you have any history of gastrointestinal or digestive disorders other than the conditions noted above?	**No**	**Yes**

Urologic History

Have you ever had any urinary tract/urologic surgery?	**No**	**Yes**
Do you have any type of kidney/renal disease (including history of kidney stones or kidney infection)?*	**No**	**Yes**

General Medical History

Do you have antiphospholipid syndrome (APS) / thrombophilia / hypercoagulability?	**No**	**Yes**

Do you have lupus?	**No**	**Yes**
Do you have rheumatoid arthritis?	**No**	**Yes**
Do you have Sjogrens Syndrome?	**No**	**Yes**
Have you ever been diagnosed with or undergone treatment for a Blood Disorder?	**No**	**Yes**
Do you have a connective tissue disorder (Ehlers-Danlos or Marfan Syndrome)?	**No**	**Yes**
Have you ever been diagnosed with or undergone treatment for Cancer?	**No**	**Yes**

Gynecological History

Have you had 3 or more miscarriages?	**No**	**Yes**
Have you ever needed IVF or other treatment to get pregnant?	**No**	**Yes**
Have you ever had any surgery or procedures on your cervix?*	**No**	**Yes**
In a previous pregnancy, have you ever had your cervix sewn or taped closed due to a weak or incompetent cervix?*	**No**	**Yes**
Have you ever had a cold knife cone biopsy (conization) to remove tissue from your cervix?*	**No**	**Yes**
Have you ever had a LEEP (Loop Electrosurgical Excision Procedure) performed to remove abnormal cells from your cervix?*	**No**	**Yes**
Have you ever had cervix cryosurgery to freeze and destroy abnormal tissue in your cervix?*	**No**	**Yes**
Have you ever been diagnosed with a uterine anomaly such as a bicorunate, unicorunate, arcuate, or septate uterus?	**No**	**Yes**
Do you have (or have you had) uterine fibroids (myomas)?	**No**	**Yes**
Have you ever had an operation to remove a fibroid or myoma from your uterus?	**No**	**Yes**

Family History

Do you or your partner have an ethnic background of Cajun/French Canadian?	**No**	**Yes**
Do you or your partner have an ethnic background of Greek/Mediterranean/Italian?	**No**	**Yes**

Do you or your partner have an Ashkenazi/Eastern European Jewish background?	**No**	**Yes**
Has anyone in your or your partner's family had a baby with anencephaly?	**No**	**Yes**
Has anyone in either your or your partner's family had Canavan Disease?	**No**	**Yes**
Have you, your partner or either your or your partner's family had a chromosomal defect?	**No**	**Yes**
Has anyone in either your or your partner's family had familial dysautonomia (FD)?	**No**	**Yes**
Have you, your partner or either your or your partner's family had a heart defect?	**No**	**Yes**
Do you, your partner or either your or your partner's family have sickle cell anemia?	**No**	**Yes**
Has anyone in your or your partner's family had sickle cell trait (SCT)?	**No**	**Yes**
Has anyone in your or your partner's family had a child with Down syndrome?	**No**	**Yes**
Has anyone in your or your partner's family had hemophilia?	**No**	**Yes**
Has anyone in your or your partner's family had Muscular Dystrophy?	**No**	**Yes**
Do you, your partner or either your or your partner's family have cystic fibrosis?	**No**	**Yes**
Has anyone in your or your partner's family had Huntington's Chorea?	**No**	**Yes**
Has anyone in your or your partner's family had Fragile X?	**No**	**Yes**
Has anyone in your or your partner's family had spinal muscular atrophy (SMA)?	**No**	**Yes**
Have you, your partner or anyone in your or your partner's family had von Willebrand Disease?	**No**	**Yes**
Do you, your partner or anyone in either family have any birth defects?*	**No**	**Yes**
Does anyone in either your or your partner's family have an intellectual disability?	**No**	**Yes**
Do you, your partner or either your or your partner's family have any children with special needs?	**No**	**Yes**
Has anyone in the family had pre-eclampsia?	**No**	**Yes**

Do your or your partner's family have any close relatives (parent, child, sibling) with diabetes?	**No**	**Yes**

Infection History

Have you been exposed to tuberculosis?	**No**	**Yes**
Have you had a rash or viral illness since your last menstrual period?	**No**	**Yes**
Have you ever been diagnosed with MRSA?	**No**	**Yes**
Have you ever been diagnosed with Hepatitis B?	**No**	**Yes**
Have you ever been diagnosed with Hepatitis C?*	**No**	**Yes**
Are you HIV positive?	**No**	**Yes**
Have you ever been diagnosed with any sexually transmitted disease (STD) - (Gonorrhea, Chlamydia, Trichomonas, HIV, HPV, or Syphilis?	**No**	**Yes**
Have you ever had a genital herpes?	**No**	**Yes**
Does your partner have a history of genital herpes?	**No**	**Yes**
Have you ever had cold sores?	**No**	**Yes**

Vaccination History

Have you ever had COVID 19 or been vaccinated for it?	**No**	**Yes**
Have you ever had chickenpox or been vaccinated against it?	**No**	**Yes**

Social History

Do you have any objections to blood transfusions?	**No**	**Yes**
Do you have a cat?	**No**	**Yes**
Do you have exposure to chemicals or radiation?	**No**	**Yes**

When was the last time you drank any alcohol?	**Never**	**Years Ago**	**Weeks Ago**	**Not Since Pregnant**	**Current**

When was the last time you smoked, vaped, or used any tobacco/nicotine products?	**Never** **Years Ago** **Weeks Ago** **Not Since Pregnant** **Current**
Do you vape or use e-cigarettes?	**Never** **Years Ago** **Weeks Ago** **Not Since Pregnant** **Current**
When was the last time you smoked a cigarette?	**Never** **Years Ago** **Weeks Ago** **Not Since Pregnant** **Current**
When was the last time you used marijuana, cocaine, meth, benzos, and/or opioids?	**Never** **Years Ago** **Weeks Ago** **Not Since Pregnant** **Current**
When was the last time you used any marijuana?	**Never** **Years Ago** **Weeks Ago** **Not Since Pregnant** **Current**
When was the last time you used any cocaine?	**Never** **Years Ago** **Weeks Ago** **Not Since Pregnant** **Current**
When was the last time you used any methamphetamines?	**Never** **Years Ago** **Weeks Ago** **Not Since Pregnant** **Current**
When was the last time you used any benzos (such as Valium, Xanax, or Ativan)?	**Never** **Years Ago** **Weeks Ago** **Not Since Pregnant** **Current**
When was the last time you used any opioids?	**Never** **Years Ago** **Weeks Ago** **Not Since Pregnant** **Current**
Are you exposed to second-hand tobacco smoke?	**No** **Current**

Options Counseling

Do you have questions about your options regarding this pregnancy?*	**No** **Yes**

Other information, history, or concerns you would like your provider to know:

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