PREGNANCY QUESTIONNAIRE

METRO PARTNERS IN WOMEN'S HEALTH

Congratulations on your pregnancy!! In order to provide the best care for you and your baby, it is necessary to obtain as much information as possible. We will need not only health/medical history from you, but also from the father of the baby and both of your families as well. **Please answer the following questions as honestly and completely as possible.**

Today's Date: _____

Patient Name: _____ Date of Birth: _____ Age: _____

Race: _____ Ethnicity: _____ Language: _____

Marital Status: _____ Partner's Name: _____

Name of Baby's Father: _____

Occupation: _____ Your highest level of education: _____

PAST GYN AND PREGNANCY HISTORY

How many times have you been pregnant? _____ How many were full term? _____

Premature? _____ Abortions? _____ Miscarriage? _____ Ectopic? _____ Multiple births? _____

Last menstrual period _____ Are you certain? O Yes O No Was it normal? O Yes O No

Age when period began _____ Length of cycle (from the start of your period to the next) _____

Date of last Pap _____ Result _____ Date of last Mammogram _____ Result _____

Were you on birth control pills at the time of conception? O Yes O No

PAST PREGNANCIES

Date DD/MM/YY	Weeks at Delivery	Length of Labor	Birth Weight	Sex M/F	Type of Delivery	Place of Delivery	Preterm Labor Y/N	Comments/Complications

MEDICAL HISTORY

The following questions regarding your medical history. Please answer the questions by checking the 'Y' column for yes and the 'N' column for no. Your provider will go over any "yes" answers with you.

	Y	N		Y	N
Diabetes			Drug allergies / latex allergies		
High blood pressure			Breast surgery / cancer		
Heart disease			Cervical surgery / D& C / laparoscopy		
Arthritis / Lupus			Operations/hospitalization		
Kidney Disease / UTI			Reaction to anesthesia		
Seizure / epilepsy / migraines			Abnormal pap smear		
Psychiatric illness			Abnormal uterus		
Depression / post partum depression			Any infertility problems		
Liver / hepatitis disease			ART treatment -		
Varicosities / phlebitis			Intestinal problems / cancer		
Thyroid problems			Do you have Mitral Valve Prolapse		
Any trauma / violence			Blood clots treated with thinners		
Had a blood transfusion			Eating disorder		
Smoke tobacco			Diagnosed with anemia		
Drink alcohol			Diagnosed with a S.T.D. (past/ present)		
Do you take illegal drugs			Diagnosed with herpes		
Rh sensitized					
Lung disease / TB /Asthma					
Seasonal allergies					

Relevant family history: _____

Any symptoms since your last menstrual period? _____

GENETIC SCREENING

(INCLUDES PATIENT, BABY'S FATHER, OR ANYONE IN EITHER FAMILY)

	Y	N
Will you be 35 or older as of estimated date of delivery?		
Thalassemia – anyone Greek, Italian, Mediterranean, or Asian descent with anemia		
Neural tube defect – spina bifida, anenocephaly, meningomyelocele		
Congenital heart defects		
Down Syndrome		
Tay-Sachs disease (Ashkenaz Jewish, Cajun or French Canadian descent)		
Canavan Disease (Ashkenaz Jewish)		
Genetic Screening		
Blood disorders or Hemophilia		
Muscular Dystrophy		
Cystic Fibrosis		
Huntington's Chorea		
Mental Retardation / Autism (if yes, was person tested for Fragile X)		
Other inherited genetic or chromosomal disorder		
Maternal Metabolic Disorder (Type 1 diabetes, PKU)		
Patient or baby's father had a child with birth defects not listed above		
Recurrent pregnancy or a stillbirth		
Medications including vitamins, herbs, over the counter medications, street drugs since last period		
Seasonal allergies		

INFECTION HISTORY

	Y	N
Are you exposed to TB or live with someone with TB?		
Do you or your partner have a history of Herpes?		
Have you had a viral illness or rash since your last menstrual cycle?		
Do you or your partner have Hepatitis B or Hepatitis C? (circle all that apply)		
Have you had a history of Gonorrhea, Chlamydia, HPV, HIV or Syphilis? (circle all that apply)		

Other: _____

_____

PSYCHOSOCIAL SCREENING

	Y	N
Do you have any problems (job, transportation, etc.) that prevent you from keeping your appointments?		
Are you feeling unsafe where you are living?		
Do you have an exposure to second hand smoke?		
Have you used drugs or alcohol in the past 2-3 months?		
Has there been any physical / mental abuse in the past 1-2 years?		
Has anyone ever forced you to do any sexual act that you did not want to do?		

What is your current stress level on a 1 – 5 scale (1 being the lowest, 5 being the highest): _____

FAMILY HEALTH HISTORY

Review the following list of health problems and check yes if they apply to parents, grandparents, siblings, aunts, uncles, or your children.

	Y	N	If Yes, please Indicate Maternal(Mother) or Paternal (Father) Relative	If Yes, age when diagnosed	If Yes, alive or deceased?
Diabetes					
Heart Disease					
Osteoporosis					
High Blood Pressure					
Stroke					
Blood clots					
Endometriosis					
Colon cancer					
Breast cancer					
Uterine Cancer					
Ovarian cancer					
Endometrial cancer					
Birth Defects					
Other					

SOCIAL HEALTH HISTORY

	Y	N	Comments
Do you smoke?			
Amounts/day:			
Do you drink alcohol?			
Amounts/day:			
Have you used drugs?			
Do you exercise?			
Do you use a seat belt?			
Have you been emotionally, sexually, or physically abused?			

SURGICAL HISTORY

Date of Surgery DD/MM/YY	Reason/Type of Surgery	Comments