Pregnancy Questionnaire

Mt Olympus Obstetrics & Gynecology

NAME:_____ **DATE OF BIRTH:**_____

Although we may have a lot of the information we are asking for, the initiation of prenatal care is an important time for us to thoroughly review your medical history and current health.

Is there a phone number where we can leave confidential messages such as test results/special instructions for today's visit as well as for future visits? If yes, phone number:_____

EMERGENCY CONTACT

Name:_____ Phone Number:_____

PAST OR CURRENT MEDICAL PROBLEMS:

(Please Check)	Yes	No	(Please Check)	Yes	No
Diabetes	❑	❑	Lung problems, asthma	❑	❑
High blood pressure	❑	❑	Breast problems	❑	❑
Heart disease	❑	❑	Autoimmune disease	❑	❑
Kidney or bladder disease	❑	❑	Uterine abnormalities	❑	❑
Neurologic problem, seizures	❑	❑	Migraines	❑	❑
Psychiatric problem	❑	❑	Anxiety, panic attacks	❑	❑
Depression, postpartum depression	❑	❑	Genital Herpes	❑	❑
Hepatitis, liver disease	❑	❑	Anemia, blood disorder	❑	❑
Varicose veins, blood clots in veins	❑	❑	Allergies, chronic sinusitis	❑	❑
Trauma, violence	❑	❑	Infertility	❑	❑
Thyroid disorder	❑	❑	Sexually transmitted infection	❑	❑
Blood transfusion	❑	❑	HIV/AIDS	❑	❑
Chicken Pox	❑	❑	Abnormal Pap	❑	❑

Other_____

If you answered yes to any of the above questions, please explain: _____

_____

SURGERIES & APPROXIMATE DATE (month/year)

1. _____ 4. _____
2. _____ 5. _____
3. _____ 6. _____

IMMEDIATE FAMILY MEMBERS WHO HAVE:

Diabetes _____ High blood pressure _____
Heart attack/stroke _____ High cholesterol _____
Thyroid problems _____ Breast/ovarian cancer _____
Uterine cancer _____ Colon cancer _____
Depression _____ 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 If yes, how many drinks per week? ❑ <1 ❑ 1-4 ❑ 5-10 ❑ >20
Have you ever used recreational drugs? ❑ Yes ❑ No If yes, what drug(s) and when? _____

_____

Do you have a history of sexual assault, rape, or child abuse? ❑ Yes ❑ No Year:_____
If you have a partner, has he or she ever hit, kicked, or threatened to harm you? ❑ Yes ❑ No
Marital status: ❑ Single ❑ Partnered/Married ❑ Divorced ❑ Widowed ❑ Other
If you have a domestic partner/spouse, what is his or her name?_____

OBSTETRIC HISTORY:

Pregnancies _____ # Living Children _____ # Multiple Births _____ # Miscarriages _____
Ectopic Pregnancies _____ # Abortions _____ Other _____

Pregnancies: (Outcome is vaginal delivery, c-section, miscarriage, ectopic, abortion, or molar)

	Year	Outcome	Hospital	Weeks @delivery	Hours of labor	Weight	Sex	Name	Epidural ?	Complications
1										
2										
3										
4										
5										
6										

First day of most recent period: _____ Are your periods regular? ❑ Yes ❑ No
Age at first period: _____ Cycle: _____ days (start to start) Usual duration: _____ days
Flow: ❑ Light ❑ Medium ❑ Heavy Birth control method prior to pregnancy: _____
Pre-pregnancy weight: _____ Height: _____ Last Pap Smear: _____ (month/year)

MEDICATION ALLERGIES/REACTION: _____

MEDICATIONS: Everything since your last period (prescriptions, vitamins, supplements, herbs, aspirin, birth control)

Medication	Dose (mg)	Times/day	Medication	Dose (mg)	Times/day
1.			4.		
2.			5.		
3.			6.		

*An HIV test will be included as part of the routine prenatal blood tests you will have done today. If you **do not** want to be tested for HIV, please notify your provider*

**Is there anything confidential you would like to discuss in private with your provider? ❑Yes ❑No

_____

_____

PRENATAL GENETIC SCREENING:

Mother of Baby	Father of Baby
Is your ancestry:	**Is your ancestry:**
African American	African American
French Canadian	French Canadian
Jewish	Jewish
Italian, Greek, Middle Eastern	Italian, Greek, Middle Eastern
Asian	Asian
Hispanic	Hispanic
Filipino	Filipino
Other_____	Other_____

Please answer all questions:

	Yes	No	Don't Know
Will you be 35 years old or older when the baby is due?	❑	❑	❑
Have you, the baby's father, or a close family member on either side ever had one of the following disorders: (A close family member is a child, mother, father, sister, brother, aunt, uncle, or grandparent)			
A. Thalassemia	❑	❑	❑
B. Neural Tube Defect, Spina Bifida, Ancephaly	❑	❑	❑
C. Congenital Heart Defect	❑	❑	❑
D. Down Syndrome	❑	❑	❑
E. Tay-Sachs	❑	❑	❑
F. Canavan Disease	❑	❑	❑
G. Sickle Cell Disease or Trait	❑	❑	❑
H. Hemophilia or Blood Disorder	❑	❑	❑
I. Muscular Dystrophy	❑	❑	❑
J. Cystic Fibrosis	❑	❑	❑
K. Huntington's Chorea	❑	❑	❑
L. Developmental Disability	❑	❑	❑
M. Any other Genetic or Chromosomal Disorder	❑	❑	❑
N. Maternal Metabolic Disorder (Type I Diabetes, PKU)	❑	❑	❑
Do you, the baby's father, or a close family member of either of you have a birth defect or a chromosomal abnormality not listed above?	❑	❑	❑
Have you or the baby's father had a stillborn baby or two or more first trimester miscarriages?	❑	❑	❑

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: _____

_____

If you are interested in any type of genetic or chromosomal screening test, please notify your provider

Signature: _____ **Date:** _____

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