PREGNANCY QUESTIONNAIRE

GENERAL INFORMATION

1. Name: ____ Occupation____________________________
2. Date of birth: _________________
3. Address: ____
4. Telephone number: Cell__________ Home__________ Work__________

PROFILE

1. Father of the baby's name ______________________________________ Occupation_________________
2. Was this pregnancy planned? ❒ Yes ❒ No
3. Are you and the baby's father happy about this pregnancy? ❒ Yes ❒ No
4. Marital status: ❒ Single ❒ Partner ❒ Married ❒ Divorced ❒ Other_________________
5. List other people living with you and their relationship to you: _______________________________________

   ____

   ____

SOCIAL HISTORY

1. Have you ever smoked? ❒ Yes ❒ No Current smoker? ❒ Yes ❒ No Quit date_________
2. Do you currently drink any alcoholic beverages? ❒ Yes ❒ No
3. Have you ever or do you now use recreational drugs? ❒ Yes ❒ No
4. Do you feel safe at home? ❒ Yes ❒ No
5. Have you ever or are you now being sexually or physically abused? ❒ Yes ❒ No
   Emotionally or verbally abused ? ❒ Yes ❒ No
6. Have you ever had professional counseling? ❒ Yes ❒ No
7. Caffeine use? ❒ Yes ❒ No

MENSTRUAL HISTORY

1. What is the date of the first day of your last menstrual period? ____________________
2. Are your menstrual cycles regular? ❒ Yes ❒ No
3. How many days are usually between the first day of one period and the first day of the next period? ________
4. What is the date of your first positive pregnancy test? __________
5. Any negative pregnancy tests after your last period? When __________
6. What was the most recent method of contraception/birth control used? ________________________________
7. When was the last time birth control was used? _______________
8. Was this pregnancy achieved with any fertility medication or procedures? ❒ Yes ❒ No

SYMPTOMS OF CURRENT PREGNANCY

1. Weight before pregnancy __________; has your weight **increased** or **decreased** over the past year? Please circle one.
2. Have you had or are you currently having any **cramping** or **abdominal pain**? ❒ Yes ❒ No
3. Have you had any vaginal **bleeding/spotting** since your last period? ❒ Yes ❒ No
4. Any problems with **nausea?** ❒ Yes ❒ No **Vomiting**? ❒ Yes ❒ No
5. Any problem with **constipation**? ❒ Yes ❒ No **Diarrhea**? ❒ Yes ❒ No
6. Are you urinating more frequently? ❒ Yes ❒ No
7. Any **pain or burning** with urination? ❒ Yes ❒ No
8. Do you have a problem with **headaches**? ❒ Yes ❒ No
9. Do you have a problem with **dizziness or fainting**? ❒ Yes ❒ No
10. Are you having **breast tenderness**? ❒ Yes ❒ No
11. Are you aware of any **lumps in your breasts**?

OBSTETRICAL HISTORY

Pregnancies_____ # Deliveries_____ # Abortions_____ # Miscarriages_____ # Ectopics_____

Stillbirths_____ # Living children _____ # Of adopted children_____

Pregnancies:

Date	Name	Sex	Delivery Type	Weeks	Baby's Weight	Hospital	MD	Pain Management

Please circle if you had any of the following complications with any previous pregnancies:

Incompetent cervix or cerclage
Diabetes
Baby that weighed less than 6 lbs or more than 9 lbs
Death of an infant
Too much or too little amniotic fluid
Post-partum depression

Post-partum hemorrhage (heavy bleeding)
Labor or rupture of membranes more than 3 weeks early
High blood pressure in pregnancy
Placenta problems
Twins or more
Uterine rupture

Any other complications not listed?____

MEDICATION ALLERGIES:

____

MEDICATIONS CURRENTLY TAKING:

____
____
____

PHARMACY:

____

YOUR MEDICAL HISTORY:

Diabetes	❒ Yes	❒ No
High blood pressure	❒ Yes	❒ No
Heart conditions	❒ Yes	❒ No
Thyroid conditions	❒ Yes	❒ No
Kidney problems	❒ Yes	❒ No
Neurologic diseases	❒ Yes	❒ No
Seizures	❒ Yes	❒ No
Depression	❒ Yes	❒ No
Anxiety	❒ Yes	❒ No
Suicidal thoughts or attempts	❒ Yes	❒ No
High cholesterol	❒ Yes	❒ No
Vaginal infections	❒ Yes	❒ No
Hepatitis/Liver disease	❒ Yes	❒ No
Bleeding disorder	❒ Yes	❒ No
Clotting disorder	❒ Yes	❒ No
Varicose veins	❒ Yes	❒ No
Asthma	❒ Yes	❒ No
Rheumatoid arthritis	❒ Yes	❒ No
Lupus	❒ Yes	❒ No
Migraines	❒ Yes	❒ No
Bladder infections	❒ Yes	❒ No
Anemia	❒ Yes	❒ No
Seasonal/environmental allergies	❒ Yes	❒ No
Any cancers	❒ Yes	❒ No

YOUR INFECTION HISTORY:

Chicken pox	❒ Yes	❒ No	HPV	❒ Yes	❒ No
Chlamydia	❒ Yes	❒ No	Partner history of genital herpes	❒ Yes	❒ No
Cytomegalovirus	❒ Yes	❒ No	Personal history of genital herpes	❒ Yes	❒ No
Gonorrhea	❒ Yes	❒ No	Parvovirus	❒ Yes	❒ No
Hepatitis B exposure	❒ Yes	❒ No	Syphilis	❒ Yes	❒ No
Hepatitis B vaccinated	❒ Yes	❒ No	TB exposure	❒ Yes	❒ No
HIV exposure	❒ Yes	❒ No	Toxoplasmosis (do you have a cat(s)?)	❒ Yes	❒ No

SURGERIES AND APPROXIMATE DATES (month/year)

1.

2.

3.

4.

IMMEDIATE FAMILY MEMBERS (your parents, sibling, children) WHO HAVE:

Condition	Family Member
Diabetes	
High blood pressure	
Heart disease	
High cholesterol	
Breast/ovarian cancer	
Dementia/Alzheimer's	

Condition	Family Member
Malignant hyperthermia	
Bleeding/clotting disorders	
Thyroid disease	
Alcoholism/drug abuse	
Depression/suicide	
Other cancers	

GENETIC HISTORY – Please answer all questions:

Are your or the baby's father members of any of the following ethnic or social groups:

Italian	❒ Yes	❒ No	Ashkenazi Jewish	❒ Yes	❒ No
Greek	❒ Yes	❒ No	Cajun	❒ Yes	❒ No
Mediterranean	❒ Yes	❒ No	French Canadian	❒ Yes	❒ No
Asian	❒ Yes	❒ No	African	❒ Yes	❒ No

Do any of your relatives or the baby's father's relatives have:

Thalessemia	❒ Yes	❒ No
Neural tube defects, spina bifida(open spine), 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 other blood disorders	❒ Yes	❒ No
Muscular dystrophy	❒ Yes	❒ No
Cystic fibrosis	❒ Yes	❒ No
Huntington's chorea	❒ Yes	❒ No
Mental retardation/autism	❒ Yes	❒ No
Tested for fragile X	❒ Yes	❒ No
Maternal metabolic disorder (type I diabetes, PKU)	❒ Yes	❒ No

Other birth defects____

Will you be 35 years old or older when baby is due? ❒ Yes ❒ No

HEALTH MAINTENANCE

1. Date of last Pap test______________________ Result:_____________________

   Any history of abnormal Pap tests? ❒ Yes ❒ No
   Any history of colposcopy or LEEP? ❒ Yes ❒ No

2. Last flu vaccine__________________________

Patient signature____ Date_________________________________

PA/RN signature____ Date_________________________________

Physician reviewed____ Date_________________________________