Name: _____ Date of Birth: _____ Today's Date: _____

Questions Regarding Your Current Pregnancy

What was the first day of your last menstrual period (LMP)? _____
Are your periods regular? Yes/No How often do they occur? _____
Where you using contraception at the time you became pregnant? Yes/No
When was your last pap smear? _____ What were the results? Normal/Abnormal
What kind of pregnancy test did you do? Urine/Blood
When was your first positive pregnancy test? _____
Since your LMP, have you had any early pregnancy symptoms (nausea, vomiting, fatigue, breast tenderness, etc)? Yes/No If yes, please describe: _____
_____
Have you had any vaginal bleeding? Yes/No If yes, please describe: _____
Have you had any problems with your prior pregnancies? Yes/No If yes, please describe: _____
_____
Since your LMP, have you used tobacco, alcohol or drugs? Yes/No If yes, please describe: _____
_____
Are you or the father of the baby of Jewish ancestry? Yes/No
Do you have cats in your home? Yes/No
Do you have contact with young children on a regular basis? Yes/No
Have you ever had chicken pox? Yes/No If no, have you ever received the varicella vaccine? Yes/No
Have you ever been the victim of domestic violence? Yes/No If yes, is the violence ongoing? Yes/No

Questions Regarding Genetic Risk/Teratology Counseling

(These questions pertain to you, the father of the baby's and both of your families. If you answer yes to any question, please provide details.)
Will you be older than 35 when the baby is due? Yes/No
Any history of thalassemia (more common in Italian, Greek, Mediterranean and Asians)? Yes/No
Any history of neural tube defects (spina bifida, anencephaly, etc)? Yes/No
Any history of congenital heart defects? Yes/No
Any history of Down Syndrome? Yes/No
Any history of Tay Sachs? (more common in Jewish and French Canadians) Yes/No
Any history of Canavan's Disease? Yes/No
Any history of Sickle Cell Disease or trait? Yes/No
Any history of hemophilia or other blood disorders? Yes/No
Any history of Muscular Dystrophy? Yes/No
Any history of Cystic Fibrosis? Yes/No
Any history of Huntington's Chorea? Yes/No
Any history of other chromosomal disorders not listed above? Yes/No
Any history of metabolic disorders not listed above (Type I DM, PKU, etc)? Yes/No
Do you or the father of the baby have any other children with any birth defects? Yes/No
Did either you or the father of the baby have any birth defects? Yes/No
Any history of women with 3 or more miscarriages? Yes/No
Have you taken any medications, other than prenatal vitamins, since your LMP (including vitamins, supplements, OTC meds, etc)? Yes/No Please list: _____
Any other genetic/environmental exposure not listed above? Yes/No

Infection History

(If you answer yes to any question, please explain.)

Do you live with someone or are have you been exposed to someone with tuberculosis? Yes/No

Do you or your partner have a history of genital herpes? Yes/No

Have you had a rash or viral illness since your LMP? Yes/No

Do you or your partner have any history of STI (gonorrhea, Chlamydia, syphilis, HIV, etc)? Yes/No

Medical History

Have you had any of the medical problems listed below? *If yes, please circle and give details.*

- Diabetes
- High blood pressure
- Stroke
- High cholesterol
- Heart problems
- Hepatitis (A, B or C)
- Gallstones
- Kidney stones
- Kidney infections
- Seizures
- Migraines
- Thyroid problems
- Blood clots in your legs or lungs
- Asthma
- Pneumonia
- Tuberculosis
- Depression
- Anxiety
- Eating disorder
- Bipolar disorder
- Alcoholism
- Drug use/abuse
- Blood transfusion
- Anemia
- Gastrointestinal problems
- Victim of domestic violence
- Victim of sexual abuse
- Breast problems
- Cancer
- MRSA infection

Please use the lines below for any medical problems not listed: _____

_____

_____

Surgical History

Have you ever had any of the common surgeries listed below? *If yes, please circle and give details.*

- Breast augmentation
- Breast reduction
- Heart surgery (bypass, valve replacement)
- Appendectomy
- Gall bladder (cholecystectomy)
- Weight loss surgery (bariatric)
- Bowel surgery
- Hernia repair
- Uterine surgery
- Cesarean section
- D&C
- Endometrial ablation
- Laparoscopy
- Ovarian cystectomy
- Oophorectomy
- Tubal ligation
- Cervical procedure (LEEP, cone, etc)
- Joint replacement
- Excision of skin cancer
- Thyroidectomy
- Back surgery (laminectomy, fusion, rods, etc)

Please use the lines below for any surgeries not listed: _____

_____

_____

Medications

Please list the names and doses of all medications you take: _____
_____
_____
_____

Allergies

Please list any medications you have allergies to and the reaction: _____
_____
Please list any food allergies you have and the reaction: _____
_____
Are you allergic to latex? Yes/No
Are you allergic to iodine? Yes/No

Family Medical History

Do any of your family members have the medical problems listed below? *If yes, please circle and give details (relationship, age at diagnosis).*

- Breast cancer
- Ovarian cancer
- Uterine cancer
- Cervical cancer
- Bowel (colon) cancer
- Blood clots in the legs or lungs
- High blood pressure
- Heart disease
- Diabetes
- Osteoporosis
- Stroke
- Thyroid problems

Please use the lines below for any medical problems not listed: _____
_____
_____

Reproductive History

How old were you when your periods started? _____
How often do your menses occur? _____
How long do they last? _____
Is the flow light, medium or heavy? _____
What methods do you use for contraception? _____
How many times have you been pregnant? _____
Have you ever had any miscarriages? Yes/No If yes, how many? _____
Have you ever had an abortion? Yes/No If yes, how many? _____
Have you ever had an ectopic pregnancy? Yes/No If yes, please describe location and treatment:
_____

Please provide details of your deliveries below:

Date	Gestation (weeks)	Hours in Labor	Baby's Weight	Gender & Name	Vaginal or C-section	Epidural	Preterm Labor	Complications	Doctor Location

Social History

Tobacco use? Yes/No If yes, how many cigarettes per day? _____ If no, have you ever? Yes/No
Prior to pregnancy, did you drink alcohol? Yes/No If yes, how many drinks per week? _____
Do you use marijuana? Yes/No If yes, how often? _____
Do you use any other street drugs? Yes/No If yes, what type and frequency? _____
What is your highest level of education? _____
What is your occupation? _____
Do you exercise regularly? Yes/No If yes, circle how many times per week: < 1 1 to 3 > 4
Marital Status (circle one): Single Married Divorced Widowed Engaged Separated Dating
Spouse/partner's name: _____
Have you ever served in the military? Yes/No Has your partner? Yes/No If yes, please provide details:
_____
Do you use your seatbelt? Yes/No If yes, circle how often: Always Usually Seldom

Immunization History

Please provide the dates of your last immunizations, if known.
Tdap (tetanus, diphtheria and pertussis): _____
Influenza: _____
Gardasil: _____
Varicella: _____
MMR (measles, mumps and rubella): _____