Dear Patient,

Congratulations on your pregnancy and welcome to Exceptional Care for Women. We are pleased and honored you have chosen our group to care for you during this exciting time. Your first visit tends to be the longest of your prenatal visits, as a comprehensive review of your health history and physical exam are performed. In an effort to provide you with the best care for your pregnancy, we have compiled a questionnaire that will allow us to collect the health history necessary to identify risks to you and your baby. Having the enclosed forms complete **prior** to your appointment time, will help ensure that your visit goes smoothly. Again, **please complete these forms prior to your visit.** They can be faxed to the office at 719-884-9963 or dropped off at the front desk Monday through Friday between 8am and 4pm.

Please begin taking an over-the-counter prenatal vitamin that has at least 400mcg folic acid and contains DHA. If you have already had care somewhere else during this pregnancy, please request copies of those medical records and bring them to your appointment for our review or drop them by the office prior to your visit.

At the conclusion of your first prenatal visit, your prenatal labs will be drawn. Our receptionist will then schedule you for a return OB visit as well as a genetic screening study, if you choose this optional testing.

We look forward to seeing you soon for your visit and thank you for allowing us to care for you and your baby.

Sincerely,

Dr. Jody Boydston, MD
Dr. Melinda Bron, MD
Dr. Abigail Brubaker, DO
Dr. Megan Cannon, MD
Dr. Amber Rodriguez, MD
Dr. Diedre Wagers, MD

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? _____
Were 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
Have you traveled internationally since or within 12 weeks of you LMP? Y / N If yes, provide details: _____
Have you been taken any narcotic pain medications since you LMP? Y / N If yes, provide details: _____

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 mental retardation or autism? 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 consecutive 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

Name: _____ Date of Birth: _____

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

Personal Medical History

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

- Diabetes
- Stroke
- Heart problems
- Gallstones
- Kidney infections
- Migraines
- Blood clots in your legs or lungs
- Pneumonia
- Depression
- Eating disorder
- Alcoholism
- Blood transfusion
- Gastrointestinal problems
- Victim of sexual abuse
- Cancer
- High blood pressure
- High cholesterol
- Hepatitis (A, B or C)
- Kidney stones
- Seizures
- Thyroid problems
- Asthma
- Tuberculosis
- Anxiety
- Bipolar disorder
- Drug use/abuse
- Anemia
- Victim of domestic violence
- Breast problems
- 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
- Heart surgery (bypass, valve replacement)
- Gall bladder (cholecystectomy)
- Bowel surgery
- Uterine surgery
- D&C
- Laparoscopy
- Oophorectomy
- Cervical procedure (LEEP, cone, etc)
- Excision of skin cancer
- Back surgery (laminectomy, fusion, rods, etc)
- Breast reduction
- Appendectomy
- Weight loss surgery (bariatric)
- Hernia repair
- Cesarean section
- Endometrial ablation
- Ovarian cystectomy
- Tubal ligation
- Joint replacement
- Thyroidectomy

Name: _____ Date of Birth: _____

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? _____

Name: _____ Date of Birth: _____

Have you ever had an ectopic pregnancy? Yes / No If yes, please describe location and treatment: _____
_____

Please provide details of your deliveries below:

	Date	Weeks at delivery?	Hours in labor?	Baby's Weight	Gender & Name	Type of Delivery (vaginal or c-section)	Epidural?	Preterm Labor?	Complications/Comments	Doctor/ Location
☆	1/1/2000	41	18	8lb 2oz	Male-Gordon	Vaginal	Yes	No	Preeclampsia in last week	R. Wilson / Georgia

☆ example

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

Name: _____ Date of Birth: _____

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): _____