

Metro Partners in Women's Health

New Pregnancy Questionnaire

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 (circle 'N' for no and 'Y' for yes).

Date _____	
Name: _____	Birthdate: _____ Age: _____
Race: _____	Marital Status: M S W D Separated Occupation: _____
Your highest level of education: _____	Language _____ Ethnicity _____
Husband/Domestic Partner _____	Name of father of the baby _____

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? Y N	Was it normal? Y N
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? Y N	

Past Pregnancies

Date/Month/Year	Weeks at delivery	Length of labor	Birth weight	Sex M/F	Type of delivery	Place of delivery	Preterm labor Y/N	Comments/Complications
1.								
2.								
3.								
4.								
5.								
6.								

Medical History

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

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

Relevant family history: _____

Any symptoms since your last menstrual period? _____

Genetic Screening

Includes patient, baby's father, or anyone in either family

<u>Will you be 35 or older as of estimated date of delivery</u>	Y	N
<u>Thalassemia – anyone Greek, Italian, Mediterranean, or Asian descent with anemia</u>	Y	N
<u>Neural tube defect – spina bifida, anenocephaly, meningomyelocele</u>	Y	N
<u>Congenital heart defects</u>	Y	N
<u>Down Syndrome</u>	Y	N
<u>Tay-Sachs disease (Ashkenaz Jewish, Cajun or French Canadian descent)</u>	Y	N
<u>Canavan Disease (Ashkenaz Jewish)</u>	Y	N

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Genetic Screening

Blood disorders or Hemophilia	Y _ N
Muscular Dystrophy	Y _ N
Cystic Fibrosis	Y _ N
Huntington's Chorea	Y _ N
Mental Retardation / Autism (if yes, was person tested for Fragile X)	Y _ N
Other inherited genetic or chromosomal disorder	Y _ N
Maternal Metabolic Disorder (Type 1 diabetes, PKU)	Y _ N
Patient or baby's father had a child with birth defects not listed above	Y _ N
Recurrent pregnancy or a stillbirth	Y _ N
Medications including vitamins, herbs, over the counter medications, street drugs since last period	Y _ N

Infection History

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

Psychosocial Screening

Do you have any problems (job, transportation, etc.) that prevent you from keeping your health care appointments?	Y _ N
Are you feeling unsafe where you are living?	Y _ N
Do you have an exposure to second hand smoke?	Y _ N
Have you used drugs or alcohol in the past 2-3 months?	Y _ N
Has there been any physical / mental abuse in the past 1-2 years?	Y _ N
Has anyone ever forced you to do any sexual act that you did not want to do?	Y _ N
What is your current stress level on a 1 – 5 scale (1 being the lowest, 5 being the highest)	_____