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 star 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.

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

Relevant family history:____

Any symptoms since your last menstrual period?________________________________

Genetic Screening

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

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

Review the following list of health problems and check yes if they apply to parents, grandparents, siblings, aunts, uncles, or your children.

Family History:	**No**	**Yes**	**If Yes, Please Indicate Maternal(Mother) or Paternal (Father) Relative**	**Age when diagnosed**	**Alive or Deceased?**
Diabetes					
Heart Disease					
Osteoporosis					
High Blood Pressure					
Stroke					
Blood clots					
Endometriosis					
Colon cancer					
Breast cancer					
Uterine Cancer					
Ovarian cancer					
Endometrial cancer					
Birth Defects					
Other					

Social History:	**No**	**Yes**	**Comments**
Do you smoke?			
Amounts/day:			
Do you drink alcohol?			
Amounts/day:			
Have you used drugs?			
Do you exercise?			
Do you use a seat belt?			
Have you been emotionally, sexually, or physically abused?			

Surgical History:		
Date of Surgery	**Type of Surgery**	**Comments**