Name:_____ DOB:_____

If you are currently pregnant, please answer the questions below:

- Date of first positive pregnancy test *(mm/dd/yy)*: _____
- Date of last menses (mm/dd/yy):_____
- List any medications you have taken during this pregnancy: _____
- _____
- Any previous ultrasound or prenatal care during this pregnancy_____
- _____
- Were you on the pill or using contraception when you became pregnant? [ ]Y [ ]N
- Does any of the following apply to your pregnancy:
- [ ] ovum/egg donor – if so age of egg donor:_____
- [ ] sperm donor
- [ ] frozen embryo – if so maternal age at time of frozen embryo:_____
- [ ] IVF
- [ ] IUI
- If applicable: name and phone number of Doctor/Group for assisted reproduction:
- _____
- Did you have genetic testing done with a previous doctor: [ ]N [ ]Y: Have you provided a copy to Women First Health Center? _____
- Have you ever had genetic ounselling: [ ]N [ ]Y: if so, when and by whom?
- _____
- Please note that many of the questions in this questionnaire refer to "father of the baby." If you used a sperm donor, please answer the questions to the best of your ability referring to the male donor.
- If you do not have a maternal genetic link to the baby, please let us know and answer those questions to the best of your ability as well.
- Name of baby's father:_____Occupation:_____
- Name of partner: _____Occupation:_____

- How much alcohol, including beer, have you drank during this pregnancy? (if none, write none) _____
- Do you have a cat? [ ]Y [ ]N
- What is the baby's father's family/ethnic background? _____

_____

- Will you be age 35 or older when the baby is born? [ ]Y [ ]N

Have you experienced or used any of the following since your last period?

[ ]Y [ ]N Nausea or vomiting
[ ]Y [ ]N Spotting or bleeding
[ ]Y [ ]N Fever or illness
[ ]Y [ ]N Exposure to x-rays or chemicals

[ ]Y [ ]N Over the counter medications?
if yes, please list:_____
[ ]Y [ ]N Prescription medications:
if yes, please list:_____

Do you or the father of the baby have a <u>family</u> history of the following (only check one of the options below if the relationship is mother, father, maternal or paternal grandparent, sister, or brother and list the relationship next to the disease):

Diabetes	[ ] N [ ]Y	Relationship _____
Heart Disease	[ ] N [ ]Y	Relationship_____
Hypertension	[ ] N [ ]Y	Relationship_____
Cancer Type	[ ] N [ ]Y	Relationship_____
Birth Defects	[ ] N [ ]Y	Relationship_____
Blood Clot Issues	[ ] N [ ]Y	Relationship_____

Obstetrical History:

Have you ever had or been treated for:

[ ]Y [ ]N Infertility
[ ]Y [ ]N Diethylstillbestrol (DES) exposure
[ ]Y [ ]N Uterine anomaly (e.g. bicornuate or unicornuate uterus, septum)
[ ]Y [ ]N History of stillbirth (intrauterine fetal demise)
[ ]Y [ ]N History of neonatal death (death after liver birth)
[ ]Y [ ]N Postpartum depression
[ ]Y [ ]N Rh Factor sensitization (maternal antibodies against fetal red blood cells causing fetal anemia)

[ ]Y [ ]N Preterm labor (onset of labor prior to 37 weeks gestation)

[ ]Y [ ]N Preterm premature rupture of membranes (rupture of membranes prior to 37 weeks gestation)

[ ]Y [ ]N Placental Previa)placental covering cervix)

[ ]Y [ ]N Abruption (placenta separation resulting in bleeding)

[ ]Y [ ]N Postpartum hemorrhage (excessive bleeding after delivery of baby causing maternal anemia)

[ ]Y [ ]N Retained placenta after delivery of baby requiring removal of placental or D&C

[ ]Y [ ]N Intrauterine growth restriction (fetus weight less than the 10th percentile during pregnancy)

[ ]Y [ ]N History of macrosomia (baby larger than 9 pounds)

[ ]Y [ ]N History of forceps or vacuum-assisted delivery

[ ]Y [ ]N Gestational diabetes (diabetes only in pregnancy)

[ ]Y [ ]N Pregnancy induced hypertension or pre-eclampsia

[ ]Y [ ]N Eclampsia (seizures in pregnancy and postpartum without prior seizure disorder)

[ ]Y [ ]N Postpartum cardiomyopathy (heart failure after delivery)

[ ]Y [ ]N Cervical insufficiency (cervical incompetence resulting in 2nd trimester miscarriage or requiring cerclage)

[ ]Y [ ]N Three or more miscarriages or abortions

[ ]Y [ ]N Group B streptococcus infection (GBS)

[ ]Y [ ]N Birth defects

Genetic Screening:

Are you a descendent of any of the following:

[ ]Y [ ]N Italian, Greek, Mediterranean or Asian background

[ ]Y [ ]N Ashkenazi Jew, Eastern European, French Canadian or Cajun background

[ ]Y [ ]N African Descent

The following questions apply to you or any close relatives (ie. grandparents, parents, aunts and uncles, brothers and sisters or children of yours and the baby's father) who have been diagnosed with:

[ ]Y [ ]N Thalassemia, (Italian, Greek, Mediterranean or Asian background)

[ ]Y [ ]N Tay Sachs, (Ashkenazi Jew, French Canadian or Cajun background)

[ ]Y [ ]N Canavan's/Gauchers, (Jewish Heritage)

[ ]Y [ ]N Sickle Cell Disease or trait (African)

[ ]Y [ ]N Any children born with neural tube defect (i.e. spina bifida, meningomyelocele, anencephaly, etc.)

[ ]Y [ ]N Congenital heart defects (e.g. ventricular or atrial septal defect, Tetralogy of Fallot)

[ ]Y [ ]N Any child with chromosomal abnormalities (e.g. Downs or Turner's Syndrome)

[ ]Y [ ]N Any blood disease (e.g. hemophilia, von Willebrand's disease)

[ ]Y [ ]N A neuromuscular disorder (e.g. muscular dystrophy)

[ ]Y [ ]N Cystic Fibrosis

[ ]Y [ ]N Huntington Chorea

[ ]Y [ ]N Any child born mentally challenged or autistic? If yes, was child tested for "Fragile X"? [ ]Y [ ]N

[ ]Y [ ]N Any other genetic or hereditary disease that is not listed? _____

_____

[ ]Y [ ]N Any child born with hydrocephaly

[ ]Y [ ]N Multiple gestation (twins, triplets, etc.)

[ ]Y [ ]N Do you have any other concerns about your family?
If yes, please list _____

Infectious History:

[ ]Y [ ]N Have you ever been exposed to hepatitis B or C or immunized for hepatitis B?

[ ]Y [ ]N Have you ever been exposed to tuberculosis?

[ ]Y [ ]N Have you or your partner ever had genital herpes?

[ ]Y [ ]N Have you had a rash or viral illness since your last menstrual period?

[ ]Y [ ]N Have you ever had any other sexually transmitted disease (e.g. gonorrhea, syphilis, chlamydia, HPV)?

[ ]Y [ ]N Have you ever had chicken pox?

[ ]Y [ ]N Have you had frequent vaginal infections?

Other Concern:

[ ]Y [ ]N Do you plan to breast feed or bottle feed?_____

[ ]Y [ ]N Are there any foods you have been told to avoid during this pregnancy?
If yes, please list_____

Maternal Medical History:

Have you ever had any of the following? If yes, circle or list the appropriate condition:

[ ]Y [ ]N Diabetes

[ ]Y [ ]N High blood pressure

[ ]Y [ ]N Heart problems such as mitral valve prolapse (MVP) or congenital heart disease (e.g.septal defect)? If yes, have you been told to take antibiotics prior to dental procedures? [ ]Y [ ]N

[ ]Y [ ]N Autoimmune disorder (e.g. Lupus, anticardiolipin antibodies, rheumatoid arthritis)

[ ]Y [ ]N Kidney disease (e.g. bladder infection, kidney stones, kidney infection)

[ ]Y [ ]N Neurologic disease (e.g. seizure, stroke, migraines)

[ ]Y [ ]N Emotional problems or psychiatric care (e.g. treatment for depression, anxiety)

[ ]Y [ ]N Liver disease (e.g. hepatitis)

[ ]Y [ ]N Varicose veins or phlebitis

[ ]Y [ ]N Clotting disoreder (e.g. deep venous thrombosis or pulmonary embolus)

[ ]Y [ ]N Bleeding disorder or anemia

[ ]Y [ ]N Thyroid diseae (hyper or hypothyroidism, Grave's Disease)

[ ]Y [ ]N Major trauma

[ ]Y [ ]N Blood transfusion

[ ]Y [ ]N Lung disease (e.g. asthma, bronchitis or pneumonia)

[ ]Y [ ]N An allergic reaction or sensitivity or any over-the-counter or prescribed medications? If yes, please list medication and reaction_____

_____

[ ]Y [ ]N Any other food or environmental allergies?
If yes, please list_____

[ ]Y [ ]N Any surgeries or hospitalizations? (Please list)_____

_____

[ ]Y [ ]N Anesthetic complications? (Please list)_____

[ ]Y [ ]N Have you ever been tested for Sickle Cell Disease?

[ ]Y [ ]N Other medical diseases not listed?

_____

[ ]Y [ ]N Allergic reaction or sensitivity to latex?

Social History During this Pregnancy:

Who do you currently live with?

[ ] Father of the baby [ ] partner/spouse [ ]parents [ ] relatives [ ] alone

[ ] other

[ ]Y [ ]N Do you smoke or chew tobacco? Amount per day_____

[ ]Y [ ]N Do you drink beer, wine or hard liquor? Amount per day_____

[ ]Y [ ]N Have you had any alcohol with this pregnancy? Amount per day_____
Number of times_____

[ ]Y [ ]N Have you used elicit or street drugs during the pregnancy?
(e.g. heroin, cocaine/crack, amphetamines, marijuana, LSD or barbiturates)

Father of the Baby's OB History:

- Has the baby's father had a child born with a defect? [ ]Y [ ]N
  If yes, please describe_____

  _____
- Has the baby's father had a stillbirth? [ ]Y [ ]N

- Has the baby's father, even in a previous relationship, experienced two or more miscarriages? [ ]Y [ ]N

- Has the baby's father ever been screened for cystic fibrosis or is anyone in either of your families affected by cystic fibrosis? [ ]Y [ ]N
- Does the baby's father have any close relatives who are mentally disabled [ ]Y [ ]N If so, whom?_____

Do you or the baby's father or close relatives in either of your families have any inherited genetic or chromosomal diseases or disorders not listed above?

[ ]Y [ ] N

If "yes", please describe: _____

Providers in this practice will administer blood or blood products in the event of a life-threatening hemorrhage. Do you object to blood or blood products in the event of a life threatening hemorrhage?

[ ]Y [ ]N

Is there any other information or suggestions you can provide that could make your obstetrical care and delivery a more memorable experience?

_____

_____

_____