Sutter Health
Palo Alto Medical Foundation

Pregnancy Questionnaire

NAME: _____ **DATE OF BIRTH:** _____

Although we may have much of the information that we are asking for in this form, the initiation of prenatal care is a most important time for both of us to thoroughly review your medical history and current health.

Is there a phone number where we can leave confidential messages such as test results/special instructions for today's visit as well as for future visits? If yes, phone number: _____ (mobile/home)

EMERGENCY CONTACT

Name _____ Phone Number _____

Pediatrician's name _____ Phone Number _____

PAST OR CURRENT MEDICAL PROBLEMS:

(Please check)	Yes	No	(Please check)	Yes	No
Diabetes	❑	❑	Lung problem, asthma, tuberculosis	❑	❑
High blood pressure	❑	❑	Breast problems	❑	❑
Heart disease	❑	❑	Rheumatoid arthritis, lupus	❑	❑
Autoimmune disease	❑	❑	Urinary incontinence	❑	❑
Kidney or bladder disease	❑	❑	Uterine abnormalities	❑	❑
Neurologic problem, seizures	❑	❑	Migraines	❑	❑
Psychiatric problem	❑	❑	Anxiety, panic attacks	❑	❑
Depression, postpartum depression	❑	❑	Herpes	❑	❑
Hepatitis, liver disease	❑	❑	Anemia, blood disorder	❑	❑
Varicose veins, blood clots in veins	❑	❑	Allergies, hay fever, chronic sinusitis	❑	❑
Trauma, violence	❑	❑	Infertility	❑	❑
Thyroid disorder	❑	❑	Sexually transmitted diseases	❑	❑
Blood transfusion	❑	❑	Abnormal Pap	❑	❑
Chicken pox	❑	❑	HIV	❑	❑

Other _____

Details of positive responses _____

_____

SURGERIES AND APPROXIMATE DATES (month/year):

1. _____ 3. _____
2. _____ 4. _____

IMMEDIATE FAMILY MEMBERS WHO HAVE:

Diabetes _____ Colon cancer _____
High blood pressure _____ Prostate cancer _____
Heart attack/stroke _____ Thyroid cancer _____
High cholesterol _____ Alcoholism _____
Breast/ovarian cancer _____ Depression/suicide _____
Dementia/Alzheimer's _____ Other _____

SOCIAL HISTORY:

Have you ever smoked? ❑ Yes ❑ No ❑ Current smoker ❑ Quit (month/year): _____

If yes, how many packs per day? ❑ <1 ❑ 1 ❑ 2 ❑ >3 For how many years? _____

Do you drink alcohol? ❑ Yes ❑ No If yes, how many drinks per week? ❑ <1 ❑ 1–4 ❑ 5–10 ❑ >20

Have you ever used recreational drugs? ❑ Yes ❑ No If yes, what drug(s) _____

Method of birth control prior to pregnancy: _____

_____

If you have a partner, has he or she ever hit you, kicked you or threatened to harm you? ❑ Yes ❑ No

What is your occupation? _____

Marital status: ❑ Single ❑ Partnered/Married ❑ Divorced ❑ Widowed ❑ Other

If you have a domestic partner/spouse, what is his or her name? _____

Highest level of education: ❑ Elementary ❑ Junior High ❑ High School ❑ College ❑ Graduate School

OBSTETRIC HISTORY:

Pregnancies _____ # Deliveries _____ # Abortions _____ # Miscarriages _____ # Ectopics _____

First day of most recent period: _____ Are your periods regular? ❑ Yes ❑ No

Pre-pregnancy weight _____

Pregnancies: (outcome is vaginal delivery, Cesarean, miscarriage, abortion or ectopic)

	Date	Outcome	Weeks	Living	Hrs Lbr	Weight	Sex	Name	Comments	Loc	M.D.	Anes
1												
2												
3												
4												
5												

Age at onset of menses: _____ Cycle: _____ days (start to start) Usual duration: _____ days

Flow: ❑ Light ❑ Medium ❑ Heavy Pain or cramps? ❑ Yes ❑ No

HEALTH CARE MAINTENANCE TESTS (month/year):

	Normal	Abnormal
Last Pap smear _____	❑	❑

MEDICATION ALLERGIES/REACTION: _____

_____

MEDICATIONS: (prescription medications, birth control, aspirin, vitamins, herbals, supplements) everything since your last period

Medication	Dose (mg)	Times per day	Medication	Dose (mg)	Times per day
1. _____			3. _____		
2. _____			4. _____		

**Is there anything confidential you would like to discuss in private with your provider? ❑ Yes ❑ No

_____

_____

PRENATAL GENETIC SCREENING:

Mother of Baby	Father of Baby
Is your ancestry:	**Is his ancestry:**
African American	African American
French Canadian	French Canadian
Jewish	Jewish
Italian, Greek, Middle Eastern	Italian, Greek, Middle Eastern
Asian	Asian
Hispanic	Hispanic
Filipino	Filipino
Other _____	Other _____

Please answer all questions:

	Yes	No	Don't Know
Will you be 35 years old or older when the baby is due?	❑	❑	❑
Have you, the baby's father or anyone in either family ever had any one of the following disorders:			
A. Thalassemia	❑	❑	❑
B. Neural Tube Defect, Spina Bifida (open spine), Anencephaly	❑	❑	❑
C. Congenital Heart Defect	❑	❑	❑
D. Down Syndrome	❑	❑	❑
E. Tay-Sachs	❑	❑	❑
F. Canavan Disease	❑	❑	❑
G. Sickle Cell Disease or Trait	❑	❑	❑
H. Hemophilia or Blood Disorder	❑	❑	❑
I. Muscular Dystrophy	❑	❑	❑
J. Cystic Fibrosis	❑	❑	❑
K. Huntington's Chorea	❑	❑	❑
L. Mental Retardation	❑	❑	❑
M. Any other Genetic or Chromosomal Disorder	❑	❑	❑
N. Maternal Metabolic Disorder (eg. Type I Diabetes, PKU)	❑	❑	❑
Do you, the baby's father, or a close family member of either of you have a birth defect or a chromosomal abnormality not listed above?	❑	❑	❑
Have you or the baby's father had a stillborn baby or three or more first trimester miscarriages?	❑	❑	❑

If you answered yes to any of the above questions, please indicate the condition and the relationship of the affected person to you or the baby's father: _____

INFECTION SCREENING:

	Yes	No	Don't Know
Do you live with someone with TB or exposed to TB?	❑	❑	❑
Do you or your partner have genital herpes?	❑	❑	❑
Have you had a rash or viral illness since your last period?	❑	❑	❑
Have you had Gonorrhea, Chlamydia, HPV or Syphilis?	❑	❑	❑

Signature _____ **Date** _____