



PROVIDER / DATE:

MR # _____

Name _____

PRENATAL QUESTIONNAIRE

PATIENT'S NAME (LAST, FIRST, MIDDLE)

ADDRESS

PREVIOUS NAMES

CITY, STATE AND ZIP CODE

IMPRINT AREA

DAY PHONE

EVENING PHONE

MESSAGE PHONE

RACE

RELIGIOUS PREFERENCE

LANGUAGE PREFERENCE

AGE

DATE OF BIRTH

OCCUPATION

EMPLOYER AND CITY

LAST GRADE COMPLETED

MARITAL STATUS

M S DP Sep D W

WHAT IS YOUR LIVING SITUATION?

Alone With baby's father
 Parents Relatives Friends Domestic Partner/Partner

FATHER OF BABY / DOMESTIC PARTNER / PARTNER

NAME

ADDRESS IF DIFFERENT FROM ABOVE

DAY PHONE

EVENING PHONE

AGE

RACE

OCCUPATION

DOES FATHER OF BABY/DOMESTIC PARTNER/PARTNER HAVE ANY MEDICAL PROBLEMS / IF YES, DESCRIBE:

CURRENTLY INVOLVED WITH BABY'S FATHER?

Yes No N/A

IN CASE OF EMERGENCY CONTACT:

YOUR LAST MENSTRUAL PERIOD

1. Date of the first day of your last period _____

Was it a normal period? Yes No

Did it occur at the right time? Yes No

2. How many days apart are your periods? _____

3. What did you last use for birth control? _____

Depo provera Norplant Birth control pills
 Diaphragm Condom/spermicide IUD
 None Other: _____

When did you stop using it? _____

4. Did you have a pregnancy test? Yes No

If yes, what kind? Urine Blood DATE: _____

PREVIOUS PREGNANCIES

How many:

- Pregnancies have you had? (Including current pregnancy) _____
- Deliveries have you had? _____
- Miscarriages have you had? _____
- Abortions have you had? _____
- Living children do you have? _____

Provider Comments: _____

PREVIOUS PREGNANCIES continued

Have any of your pregnancies involved:

- A baby weighing less than 5 lbs 8 oz? Yes No
- A baby weighing more than 9 lbs? Yes No
- Premature labor? (before 8th mo.) Yes No
- Cesarean section? Yes No

Provider Comments: _____

PREGNANCY RISK FACTORS

Since the pregnancy began have you?

- Had vaginal bleeding that required a visit to the Emergency Department? Yes No
- Had any severe nausea and vomiting that required a visit to the Emergency Department? Yes No
- Had a fever higher than 100 degrees? Yes No
- Smoked cigarettes in the last 3 months? Yes No
If yes, about how many per week do you smoke? _____
- Had any alcoholic beverages? Yes No
- Taken any medications or drugs? Yes No
If yes, LIST: _____

- At the time you conceived were you ...
 Wanting to get pregnant, Wanting to get pregnant, but not at this time, or Not wanting to get pregnant at all?

Provider Comments: _____

PLEASE GIVE THE YEARS AND PARTICULARS OF ALL PREVIOUS PREGNANCIES

(Fill in "year," "where," "length of pregnancy," "hours of labor," "sex," and "wt." Use a separate sheet of paper if you have had more than 6 pregnancies.)

YEAR	WHERE	LENGTH OF PREGNANCY	HOURS OF LABOR	TYPE OF ANESTHESIA	TYPE OF DELIVERY	SEX	WT	COMPLICATIONS

YOUR MEDICAL HISTORY	Yes	No	Provider Comments	SOCIAL CIRCUMSTANCES			
<i>Are you allergic to any medications?</i>				1. Have you ever sought professional help for an emotional problem?	Yes	No	Provider Comments
If yes, LIST:							
<i>Do you have or have you ever had:</i>				2. Is your work or home stressful?			
1. Abnormal Pap test				3. Is your living situation unsafe/unstable?			
2. Anemia/blood transfusions				4. Are you constantly dieting?			
3. Arthritis or bone fractures				5. Do you foresee any problems coming to prenatal checkups?			
4. Asthma				6. Do you have any fears about this pregnancy or baby?			
5. Bleeding tendencies				7. Within the last year - or since you have been pregnant - have you been hit, slapped, kicked or otherwise physically hurt by someone?			
6. Blood clots in veins or lungs				8. Are you in a relationship with a person who threatens or physically hurts you?			
7. Breast surgery				9. Has anyone forced you to have sexual activities that made you uncomfortable?			
8. Cancer				10. Are you worried about your partner's drug or alcohol use?			
9. Chicken pox				FATHER OF BABY HISTORY (IF APPLICABLE)			
10. Chlamydia				<i>Has the father of the baby?</i>	Yes	No	DON'T KNOW
11. Diabetes				1. Had any blood transfusions?			Dr. Comments
12. Frequent bladder infections				2. Tested positive for HIV?			
13. Gall bladder disease				3. Had herpes?			
14. Heart disease				4. Smoked cigarettes?			
15. Hepatitis				POSTPARTUM CONTRACEPTION			
16. Herpes (you or your partner)				1. Do you plan to begin a birth control method after your baby is born? <input type="checkbox"/> Yes <input type="checkbox"/> No			
17. High blood pressure				2. If yes, what will you use?			
18. HIV				<input type="checkbox"/> Vasectomy	<input type="checkbox"/> Birth control pills	<input type="checkbox"/> Diaphragm	
19. HPV or genital warts				<input type="checkbox"/> Condom/spermicide	<input type="checkbox"/> IUD	<input type="checkbox"/> Depo provera	
20. Kidney stones				<input type="checkbox"/> Norplant	<input type="checkbox"/> Tubal sterilization		
21. Lung disease				Other: _____			
22. Major surgery/hospitalization				Provider Comments: _____			
23. Mental illness / depression				_____			
24. Migraine headaches				_____			
25. Problems w/ anesthesia				_____			
26. Problems getting pregnant/infertility				_____			
27. Seizures/epilepsy				_____			
28. Syphilis				_____			
29. Thyroid problems				_____			
30. Tuberculosis				_____			
FAMILY HISTORY				BREAST FEEDING PLAN			
<i>Has anyone in your family ever had?</i>	Yes	No	Which family member?	1. Do you plan to breastfeed this baby? <input type="checkbox"/> Yes <input type="checkbox"/> No			
1. Asthma?							
2. Tuberculosis?							
3. Heart disease?							
4. Hypertension?							
5. Kidney disease?							
6. Diabetes?							
7. Seizures/epilepsy?							
8. Sickle cell / thalassemia?							
9. Twins?							
10. Birth defects?							