

Pregnancy Questionnaire

Patient name: _____ Physician: _____

Please answer the following questions carefully at your leisure and bring the answers along with you to your first obstetrical visit. Your answers may help identify problems with your pregnancy and/or indicate special tests necessary to evaluate your health or that of your unborn baby. Undoubtedly, your responses will assist the obstetricians at Los Olivos Women's Medical Group as they seek to improve your medical care. Thank You.

Family History and Genetic screening

1. Certain genetic diseases are more common in certain ethnic groups. Please check if you or the baby's father is one of these ethnic groups.

Yes No Eastern European Jewish ancestry
If yes, have you had Tay-Sachs screening tests? Yes No
If yes, have you had a Canavan screening test? Yes No

Yes No African American
If yes, have you had sickle cell screening? Yes No

Yes No European Ancestry
If yes, have you had cystic fibrosis screening? Yes No

Yes No Mediterranean Ancestry or Southeast Asian Ancestry
If yes, have you had screening for inherited forms of anemia such as thalassemia? Yes No

2. Have you or the baby's father had a child born with a birth defect? Yes No
If yes, please describe: _____

3. Did either you or the baby's father have a birth defect? Yes No
If yes, please describe: _____

4. Please describe any abnormalities that have occurred in children of your family or the baby's father's family (eg, mental retardation, birth defects, deformities or inherited diseases such as hemophilia, muscular dystrophy, cystic fibrosis or fragile X syndrome).

5. Do you have any other concerns about birth defects or inherited disorders?

6. Yes No Will you be 35 years or older at the time the baby is born?

Yes No Will the father be 50 years or older at the time the baby is born?

1. Have you had a temperature of 103 or greater at any time during the first two months of your pregnancy? Yes No
2. Do you own a cat?
If yes, does your cat use a litter box? Yes No
3. Have you used any hot tubs, saunas or steam baths during this pregnancy? Yes No
4. Do you have a history of a second trimester miscarriage or an incompetent cervix? Yes No
5. Have you had problems with preterm labor during a previous pregnancy? Yes No
6. Have you been treated for infertility?
List treatments: _____ Yes No
7. Do you have any known abnormality or anomaly of your uterus? Yes No
8. Did your mother use DES when she was pregnant with you? Yes No
9. Do you and/or the baby's father have a history of herpes?
How often do you have outbreaks/year? _____ Yes No
10. Do you have a history of venereal disease, such as gonorrhea, chlamydia or HIV? Yes No
11. Have you had any abnormal pap smears?
Dates: _____ Yes No
12. Have you had a surgical procedure on your cervix such as a LOOP, LEETZ, or cone biopsy? Yes No
13. Do you have any close family members with tuberculosis? Yes No
14. Do you have a history of hepatitis, jaundice or liver disease? Yes No
15. Have you used cocaine, marijuana, or other drugs during this pregnancy? Yes No
16. Have you used alcohol during this pregnancy? Yes No
17. Do you smoke cigarettes?
If yes, how many packs per day? _____ Yes No
18. Do you have any religious objections to any form of medical treatment (ie blood transfusions)? Yes No
19. Do you or any family member have a history of problems with anesthesia? Yes No
20. I have a latex allergy. Yes No
21. Do you feel unsafe where you live? Yes No
22. In the past year, have you been threatened, hit, slapped or kicked by anyone you know? Yes No

I have had chicken pox or have had a vaccination for it. Please initial _____

I am aware of the risks to myself and my baby of using alcohol, illicit or recreational drugs and smoking during pregnancy. Please initial _____

List all medications taken since your last menstrual period including prescription, over-the-counter and herbal medications:

Please list any surgical procedure that you have had:

Please list any concerns that you have:

Patient signature: _____ Date: _____ MD: _____