

  
**LOS OLIVOS**  
WOMEN'S MEDICAL GROUP  
**OBSTETRICS – GYNECOLOGY – INFERTILITY**

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**Congratulations on your pregnancy!**

The Los Olivos physicians and staff look forward to working with you during your pregnancy. Please fill out the Genetics Questionnaire and the Prenatal Questionnaire prior to your first appointment and bring them to your appointment. The first OB appointment is usually scheduled between 10 and 12 weeks of pregnancy. It is helpful if you know the first day of your last menstrual period (LMP) or when you ovulated. By tradition, the pregnancy first starts with your LMP. If you experience any problems or have any bleeding prior to the first OB appointment, please call for an earlier appointment.

Folate or folic acid, 400 mcg to 1.0 mg, should be taken each day during the first 13 weeks of pregnancy. This is included in most prenatal vitamins, which can be purchased without a prescription.

At your first obstetric visit, you will be given a copy of the Los Olivos pregnancy guide, which provides helpful information about pregnancy. The guide answers commonly asked questions and gives information on medications that can be used safely during pregnancy. You can also access this information at the Los Olivos Women's Medical Group website: [www.lowmg.com](http://www.lowmg.com). During your first prenatal appointment, the paperwork you have completed will be reviewed, your physical exam updated, and prenatal laboratory testing will be recommended. You will also be given an additional informational booklet and genetic screening and testing options will be discussed, including the California Prenatal Genetic Screening test for Trisomy 18 and 21.

Please feel free to ask any questions during any of your visits. We recommend that you write your questions down so that all of your questions can be answered. Between appointments, you may call during office hours and leave non-urgent questions on the voice mail. Your calls will be returned within 24 hours.

We are pleased that you have chosen our office for your care. In establishing a successful relationship with you, our philosophy is to work together as partners in your care towards a safe and healthy pregnancy and delivery. We strive to make this important event a wonderful and memorable experience.

The Los Olivos Physicians and Staff

LOS  LIVOS  
**Genetics 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.

**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?

Please list any surgical procedure that you have had:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

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?  Yes  No  
If yes, does your cat use a litter box?  Yes  No  
Who changes the litter box \_\_\_\_\_
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?  Yes  No  
List treatments: \_\_\_\_\_
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?  Yes  No  
How often do you have outbreaks/year? \_\_\_\_\_
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?  Yes  No  
Dates: \_\_\_\_\_
12. Have you had a surgical procedure on your cervix such as a LEEP, 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. Do you have a latex allergy?  Yes  No
21. In the past year, have you been threatened, hit, slapped or kicked by anyone you know?  Yes  No
22. I have had chicken pox or have had a vaccination for it.  Yes  No
23. I have been vaccinated for whooping cough within the last three years.  Yes  No
24. I am aware of the risks to myself and my baby of using alcohol, illicit or recreational drugs and smoking during pregnancy.  Yes  No

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

\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

Please list any concerns that you have:

\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

Patient signature: \_\_\_\_\_ Date: \_\_\_\_\_

Due Date: \_\_\_\_\_

**Patient name:** \_\_\_\_\_ **Age:** \_\_\_\_\_  
**Home phone:** \_\_\_\_\_ **Name of baby's father:** \_\_\_\_\_  
**Your work phone:** \_\_\_\_\_ **Father's work phone:** \_\_\_\_\_  
**Your cell phone:** \_\_\_\_\_ **Father's cell phone:** \_\_\_\_\_

**If there is a family history of the following conditions please check next to that condition:**  NONE

- |   |  |   |                                      |
|---|--|---|--------------------------------------|
| <input type="checkbox"/> Sickle cell anemia | <input type="checkbox"/> Tay Sachs           | <input type="checkbox"/> Mental retardation | <input type="checkbox"/> Twins       |
| <input type="checkbox"/> Bleeding problem   | <input type="checkbox"/> Stillbirths         | <input type="checkbox"/> Cystic fibrosis    | <input type="checkbox"/> Thalassemia |
| <input type="checkbox"/> Heart defects      | <input type="checkbox"/> Neural tube defects | <input type="checkbox"/> Musculodystrophy   |                                      |
- Any hereditary problems **Please explain:**

**List any illnesses in your family:**  None

Your partner: \_\_\_\_\_  
 Your mother: \_\_\_\_\_  
 Your father: \_\_\_\_\_  
 Your brothers/sisters: \_\_\_\_\_

**If you have a history of the following conditions please check next to that condition:**  NONE

- |   |  |  |  |   |
|---|--|--|--|---|
| <input type="checkbox"/> Asthma           | <input type="checkbox"/> Hepatitis                   | <input type="checkbox"/> Colitis               | <input type="checkbox"/> Infertility         | <input type="checkbox"/> Alcohol use        |
| <input type="checkbox"/> Diabetes         | <input type="checkbox"/> Herpes                      | <input type="checkbox"/> Heart disease         | <input type="checkbox"/> Genital warts       | <input type="checkbox"/> Seizure disorder   |
| <input type="checkbox"/> Anemia           | <input type="checkbox"/> Depression                  | <input type="checkbox"/> Fibroids              | <input type="checkbox"/> Skin disorder       | <input type="checkbox"/> Blood transfusion  |
| <input type="checkbox"/> Drug use         | <input type="checkbox"/> Smoking                     | <input type="checkbox"/> Group B streptococcus | <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Abnormal pap smear |
| <input type="checkbox"/> Thyroid disorder | <input type="checkbox"/> Frequent bladder infections | <input type="checkbox"/> Preterm labor         |  |   |

**Please explain any of the above check marks and list any other conditions:**

**List any surgeries:** \_\_\_\_\_

**Pregnancy history:**

Last menstrual period: \_\_\_\_\_ Was this a planned pregnancy? yes  no   
 Last contraceptive used / date last used: \_\_\_\_\_ Last pap smear: \_\_\_\_\_  
 Date of ovulation (if known): \_\_\_\_\_ Date of positive pregnancy test: \_\_\_\_\_  
 Any illness, x-rays or injuries during pregnancy? yes  no   
 Have you had chicken pox? yes  no  unsure   
 How tall are you? \_\_\_\_\_ What is your current weight? \_\_\_\_\_ What is your pre-pregnancy weight? \_\_\_\_\_  
 Please list any medications used during the pregnancy. Are you taking prenatal vitamins? yes  no

Do you have allergies to any medications? Please list \_\_\_\_\_

**Previous pregnancies:** Number of children now living \_\_\_\_\_ Number of live births \_\_\_\_\_  
 Number of miscarriages \_\_\_\_\_ Number of pregnancy terminations \_\_\_\_\_  
 Number of ectopic pregnancies \_\_\_\_\_

**Were there any complications to you or the baby during any of the pregnancies or deliveries?**  NO

Date of delivery	Hospital	Vaginal or cesarean	Natural or epidural	Weight of baby	Gestational age at del.	Length of labor

Completed by: \_\_\_\_\_ Date: \_\_\_\_\_