LOS OLIVOS
WOMEN'S MEDICAL GROUP

LABEL

Prenatal Questionnaire Due Date:__________________

Patient name: Age: Date:
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:
☐ Sickle cell anemia ☐ Tay Sachs ☐ Mental retardation ☐ Twins
☐ Bleeding problem ☐ Stillbirths ☐ Cystic fibrosis ☐ Thalassemia
☐ Heart defects ☐ Neural tube defects ☐ Musculodystrophy
☐ Any hereditary problems **Please explain:**

List any illnesses in your family:
Your partner:
Your mother:
Your father:
Your brothers/sisters:

If you have a history of the following conditions please check next to that condition:
☐ Asthma ☐ Hepatitis ☐ Colitis ☐ Infertility ☐ Alcohol use
☐ Diabetes ☐ Herpes ☐ Heart disease ☐ Genital warts ☐ Seizure disorder
☐ Anemia ☐ Depression ☐ Fibroids ☐ Skin disorder ☐ Blood transfusion
☐ Drug use ☐ Smoking ☐ Group B streptococcus ☐ High blood pressure
☐ Thyroid disorder ☐ Frequent bladder infections ☐ Preterm labor ☐ Abnormal pap smear
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?

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

Patient signature:______________________________Date:__________________