**Prenatal history questionnaire**

**PART 1**

* When was your last menstrual period? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* Do you have any allergies? (such as medications, environmental, latex, or other allergens?) Please list allergen and reaction.
	+ **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**
	+ **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**
	+ **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**
	+ **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**
	+ **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**
* Do you currently have any medical issues? (For example, but not limited to: high blood pressure, heart problems, diabetes, an under/over active thyroid?)
	+ If no, please proceed to next question. If yes, please list medical problem, the doctor that treats you and any medication prescribed.
	+ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
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* Have you recently been treated with any short-term medication?
	+ If no, please proceed to next question. If yes, please list problem that required medication the medication that was prescribed and the length of time you took medication.
	+ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
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* Have you ever had surgery? If no, please proceed to next question. If yes, please list surgical procedure, date of procedure, facility it was done at, and physician who performed procedure.
	+ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
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* Are you currently being treated for (or have a history of) depression, anxiety, bi-polar, or other mental illness?

If no, please proceed to next question. If yes, please list physician who follows you and what medication you are currently taking.

* + \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
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* Do you have a history of alcohol, recreational drug use or drug dependency? If yes, please list what drugs you have recently used or are currently using: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
	+ If yes, do you take medication (such as Methadone, Suboxone, or Subutex) to help with this (list med and prescribing MD)? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
	+ Have you ever been screened for Hepatitis C (if positive drug history)? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* Do you currently smoke cigarettes or use tobacco products?
	+ If yes, how many packs per day do you smoke? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* In the case of an emergency or life-threatening situation, **would you permit a blood transfusion (**receiving donor blood due to losing too much blood after delivery and/or surgery)?

YES\_\_\_\_\_\_\_\_ NO\_\_\_\_\_\_\_\_\_

 If you would **NOT** permit a blood transfusion due to religious beliefs, do you have a card or document stating this, that we can copy to keep in your medical record?

* Current medications (includes OTC/supplements/prescriptions…even prenatal vitamins!)
	+ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
	+ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
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	+ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Family History

Do you or your significant other have a personal or family history of any of the following? Check all that apply:

\_\_\_\_\_Thalassemia (Italian, Greek, Mediterranean, or Asian background)

\_\_\_\_\_Neural Tube Defect (Spina bifida or Spina bifida occulta, anencephaly)

\_\_\_\_\_ Cleft lip and/or cleft palate

\_\_\_\_\_ Clubbing of one or both feet

\_\_\_\_\_Heart defect that may or may not have required surgery

\_\_\_\_\_Down Syndrome

\_\_\_\_\_Tay-Sachs (Jewish, Cajun, or French-Canadian)

\_\_\_\_\_ Canavan disease

\_\_\_\_\_ Huntington’s Chorea

\_\_\_\_\_Sickle cell disease

\_\_\_\_\_Hemophilia

\_\_\_\_\_Blood clots

\_\_\_\_\_Stroke or sudden, unexpected death at an early age

\_\_\_\_\_Muscular Dystrophy

\_\_\_\_\_ Cystic Fibrosis

\_\_\_\_\_Mental retardation/Autism/Fragile X

Any other inherited genetic or chromosomal disorder?

If you indicated any family history above, please list relation.

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

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Does anyone in your family (blood relation) have:

(F- father, M-mother, PA- paternal aunt, MA- maternal aunt, PGF- paternal grandfather, MGF- maternal grandfather, MGM-maternal grandmother, PGM-paternal grandfather, S-sister, B-brother, 1/2S- half-sister, 1/2B- half-brother. Please note, half siblings share either the same mother or same father. They are not the same as step siblings. Step siblings are not blood related).

\_\_\_\_\_\_ Arthritis

\_\_\_\_\_\_\_\_\_ Autoimmune disease such as lupus, Sjogren’s, rheumatoid arthritis

\_\_\_\_\_\_\_\_\_ Cancer

\_\_\_\_\_\_\_\_\_ Diabetes

\_\_\_\_\_\_\_\_\_ Heart disease

\_\_\_\_\_\_\_\_\_ Hypertension

\_\_\_\_\_\_\_\_\_ Stroke

\_\_\_\_\_\_\_\_\_ Sudden cardiac event that resulted in death, prior to age 50.

 Infection History

* Have either you or your significant other ever been exposed to or treated for tuberculosis in the past? \_\_\_\_\_\_ yes \_\_\_\_\_\_\_ no
* Have either you or your significant other ever been diagnosed with genital herpes or have ever had an outbreak of genital lesions? \_\_\_\_\_yes \_\_\_\_\_no
* Have you had a rash or viral illness since your last menstrual period? \_\_\_\_\_yes \_\_\_\_\_no
* In the past (or recently), have you ever been diagnosed with (please circle) gonorrhea, chlamydia, syphilis, herpes (genital or oral), or HPV (human papilloma virus)? If yes, did you and/or partner complete prescribed treatment?
* Have you or your partner ever been diagnosed with Hepatitis B, Hepatitis C, or HIV?
	+ If yes, please indicate when diagnosis occurred and any relevant treatment:

**PART 2 (Only complete if you have been pregnant in the past)**

* How many times have you been pregnant, NOT including this pregnancy? \_\_\_\_\_\_\_\_\_\_\_
* Have you ever had a miscarriage? \_\_\_\_\_\_\_\_\_\_
	+ Did you require a D&C (surgical procedure done after miscarriage to remove contents of uterus that did not pass on its own)?

* + Have you ever terminated a pregnancy?
		- If yes, did you have any complications? (please list below)
* Have you ever had a pregnancy loss/stillbirth after 12 weeks?
	+ If yes, please include how many weeks gestation you were and any relevant information pertaining to loss: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* Were any of these pregnancies delivered preterm (less than 36 weeks)?
	+ If yes (note weeks and reason) :
		- \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
		- \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
		- \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
		- \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

* Date/place of delivery (physician name/ infant weight /gestation:
	+ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
	+ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
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* How many vaginal births/Cesareans have you had?
	+ Any complications (shoulder dystocia, cord prolapse, perineal trauma, hemorrhage, blood transfusion, NICU admission for neonate)? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
	+ If you had a Cesarean: Why?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* Did you have any problems during your pregnancy such as hypertension, diabetes, seizure disorder, hyper/hypothyroid that required medication management or frequent lab work?
	+ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* Are your children healthy or do they have any long-term problems that require ongoing medical management? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Please include any other information that you would like to share with us**: