# Prenatal Questionnaire

**Name:** ______________________________________________ **DOB:** ________________ **Date:** _______________

Race: ☐Caucasian ☐African American ☐Latin ☐Asian ☐Other: ___________________

Marital Status: ☐Married ☐Single ☐Separated ☐Divorced ☐Widowed

Father of Baby: ________________________________________ Age: _______ Race: _________________________

Are you employed? ☐Yes ☐No If yes, who is your employer? _____________________________________________

What is your highest level of education? __________________ Primary Language: ______________________

**MENSTRUAL HISTORY**

What was the first day of your last menstrual period? ____/____/____ ☐Definite ☐Estimate ☐Unknown

How often are your periods? _________________________ How long do your periods last? _______________________

How old were you when you started having periods? __________________

Were you on birth control when you got pregnant? ☐Yes ☐No Date of first positive pregnancy test? ____/ ____/____

Have you had any significant pain since becoming pregnant? ☐Yes ☐No

Have you had any bleeding since your positive pregnancy test? ☐Yes ☐No

What symptoms of pregnancy have you been having?

☐Nausea ☐Vomiting ☐Breast Tenderness ☐Urinary Frequency ☐Pelvic Pressure ☐Weight Gain

☐Other: ______________________________________________________________________________________

**PAST PREGNANCY**

How many times have you been pregnant? ____________ How many full term deliveries have you had? _____________

How many premature pregnancies (before 37 weeks) have you had? ___________ How many miscarriages? __________

How many abortions have you had? ________ Have you ever had an ectopic pregnancy (tubal pregnancy)? ___________

Have you ever had twins or triplets? _________________ How many living children do you have? __________________

## PAST PREGNANCIES

| Date (Mo./Yr) | How many weeks pregnant? | Birth Weight | Male / Female | Vaginal/ C-Section | Premature Labor | Any problems with delivery or baby? | Place of Birth |
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## MEDICAL HISTORY

| Do **you** or did you ever have any of the following medical problems? | Yes | No |
|---|---|---|
| Diabetes | | |
| Hypertension | | |
| Heart Disease | | |
| Autoimmune Disorder | | |
| Kidney Disease/<br>Frequent Urinary Tract Infections | | |
| Seizures/Epilepsy | | |
| Migraine Headaches | | |
| Psychiatric Disorder | | |
| Depression | | |
| Hepatitis/Liver Disease | | |
| Varicose Veins | | |
| Phlebitis/Blood Clots in Legs or Lungs | | |
| Thyroid Problems | | |
| Rh Blood Negative Factor | | |
| Lung Problems/Asthma | | |
| Seasonal Allergies | | |

**Do you use**:

☐ Yes ☐ No ***Alcohol*** – if yes,
Have you had a drink containing alcohol in the past 12 months? ______
How Often? _____ How many in a day? ________ How often did you have 6 or more on one occasion? ____

☐ Yes ☐ No ***Cigarettes*** – if yes,
How often? ____ How soon after you wake up?____
How many a day?____ Are you interested in quitting? ____

☐ Yes ☐ No Illicit ***recreational drugs*** (Marijuana, Cocaine, etc.) If you would not feel comfortable writing anything down, please discuss directly with your physician. Specify ______________________________________

Do you have any problems with violence or abuse? ☐Yes ☐No if yes, describe ________________________

Please list any prescription or over the counter medications you have taken since your last menstrual period:

______________________________________________________________________________

**Medication Allergies**: ________________________________ Other: ____________________________

Do you have a **Latex Allergy**? ☐Yes ☐No Have you ever had any breast problems? ☐Yes ☐No

Have you ever been diagnosed with any of the gynecological problems listed below?

☐Ovarian cysts ☐Fibroids ☐Abnormal uterine bleeding ☐Polycystic ovaries ☐Uterine abnormalities

☐DES exposure ☐Other: ____________________________________________________________

Have you ever been evaluated for infertility? ☐Yes ☐No Have you ever had an abnormal pap smear? ☐Yes ☐No

Have you ever had any surgeries? Please list:

Surgery: ______________________________________________________ Date: ____________

Surgery: ______________________________________________________ Date: ____________

Surgery: ______________________________________________________ Date: ____________

Have you ever had any biopsies? ☐Yes ☐No if yes, what kind? ______________________

Have you ever had any problems with anesthesia? ☐Yes ☐No If yes, what were the complications? ____________

Have you ever been hospitalized overnight? ☐Yes ☐No If yes, why? ____________________________

## YOUR FAMILY MEDICAL HISTORY

| Has anyone in your family been diagnosed with the following? (Parents, Grandparents, Siblings, Children) | Yes (If yes, Who?) | No |
|---|---|---|
| Diabetes | | |
| Heart Attack/Heart Disease | | |
| Stroke/Blood Clots | | |
| High Blood Pressure | | |
| Cancer (breast, uterine, ovarian, colon) | | |
| Autoimmune Disease | | |
| Thyroid Disorder | | |
| Psychiatric Disorder | | |

## GENETIC HISTORY

| Has anyone in your family or the father of the baby's family ever had the following? | Yes (if yes, who?) | No |
|---|---|---|
| Anemia/Blood Disorders | | |
| Italian, Greek, Mediterranean Decent | | |
| Spina Bifida | | |
| Tay-Sachs | | |
| Jewish, French Canadian , or Cajun | | |
| Canavan's Disease | | |
| Sickle Cell Anemia | | |
| African American | | |
| Hemophilla/Free Bleeder | | |
| Muscular Dystrophy | | |
| Cystic Fibrosis | | |
| Huntingdon's Chorea | | |
| Mental Retardation/Autism | | |
| Fragile X Syndrome | | |
| Inherited or Chromosomal Disorders | | |
| Metabolic Disorders (PKU) | | |
| Cleft Lip/Palate | | |
| Deafness or Blindness at Birth | | |
| Birth Defects | | |

Will you be 35 or older when you deliver? ☐Yes ☐No

**INFECTION HISTORY**

Have you ever been exposed to Tuberculosis or ever had a positive TB test? ☐Yes ☐No

Do you or your partner have Herpes, Fever Blisters, or Cold Sores? ☐Yes ☐No

Have you had any rashes or viruses or illnesses since your last menstrual period? ☐Yes ☐No if yes, Describe ______

Have you ever been diagnosed with any of the following sexually transmitted infections?

☐Chlamydia ☐Gonorrhea ☐Herpes ☐Genital Warts ☐HPV

☐HIV ☐Hepatitis B ☐Hepatitis C ☐Trichomoniasis ☐Syphilis

Have you ever had chicken pox? ☐Yes ☐No Do you have cats in your home? ☐Yes ☐No

Have you ever received a blood transfusion? ☐Yes ☐No If yes, when? ________________________________________

Would you take a blood transfusion if it were an urgent medical necessity? ☐Yes ☐No

**SUMMARY**

Is there anything else we need to know about you that has not been covered?

______________________________________________________________________________

______________________________________________________________________________

Do you have any special questions for your provider?

______________________________________________________________________________

______________________________________________________________________________

______________________________________________________________________________

______________________________________________________________________________

Are you considering adoption? ☐Yes ☐No ☐Need to Discuss

**CONSENT FOR PRENATAL ULTRASOUNDS / TESTING**

In understand that ultrasound examinations may be recommended by Contemporary OBGYN of Western Kentucky. I understand that these exams are used to help reassure me that the baby is growing as expected and provide my provider reassurance that the baby is doing well.

Additionally, they are used to help establish my due date, look at the baby's developing organs and provide information about other potential problems with the baby, the amniotic fluid and placenta which may affect mine or my baby's health. Furthermore, additional testing is recommended for infectious diseases per the American College of Obstetricians & Gynecologists including Human Immunodeficiency Virus, hepatitis, syphilis and toxicology screening as these can be associated with increased risk of miscarriage, poor fetal growth, fetal abnormalities as well as numerous other problems that could potentially affect my health or my baby's health.

I realize that although ultrasounds may detect many possible problems, they do not detect ALL problems and a normal ultrasound does not ensure a completely normal baby without any problems or birth defects due to the limits of the study.

I have given Contemporary OBGYN of Western Kentucky permission to perform the necessary screening today and at any other time during my pregnancy when it may become necessary. Insurance policies vary, and it is the patient's responsibility to know their benefits. I understand that I am responsible to pay for any ultrasounds that are not covered by my insurance.

______________________________ __________________________

Patient Name Date

______________________________

Patient Signature

______________________________

Witness

Name ________________________________________

Your Date of Birth ____________________________________

Baby's Date of Birth (if you have delivered): _______________

SAMPLE QUESTION:
As you are pregnant or have recently had a baby, we would like to know how you are feeling.
Please check the answer that comes closest to how you have felt **IN THE PAST 7 DAYS**, not just how you feel today.

Here is an example, already completed.

❑ I have felt happy:

❑ Yes, all the time
■ Yes, most of the time
❑ No, not very often
❑ No, not at all

This would mean: "I have felt happy most of the time" during the past week. Please complete the other questions in the same way

**In the past 7 days:**

**1. I have been able to laugh and see the funny side of things**
- ❑ As much as I always could
- ❑ Not quite so much now
- ❑ Definitely not so much now
- ❑ Not at all

**2. I have looked forward with enjoyment to things**
- ❑ As much as I ever did
- ❑ Rather less than I used to
- ❑ Definitely less than I used to
- ❑ Hardly at all

***3. I have blamed myself unnecessarily when things went wrong**
- ❑ Yes, most of the time
- ❑ Yes, some of the time
- ❑ Not very often
- ❑ No, never

**4. I have been anxious or worried for no good reason**
- ❑ No, not at all
- ❑ Hardly ever
- ❑ Yes, sometimes
- ❑ Yes, very often

***5. I have felt scared or panicky for no very good reason**
- ❑ Yes, quite a lot
- ❑ Yes, sometimes
- ❑ No, not much
- ❑ No, not at all

***6. Things have been getting on top of me**
- ❑ Yes, most of the time I haven't been able to cope at all
- ❑ Yes, sometimes I haven't been coping as well as usual
- ❑ No, most of the time I have coped quite well
- ❑ No, I have been coping as well as ever

***7. I have been so unhappy that I have had difficulty sleeping**
- ❑ Yes, most of the time
- ❑ Yes, sometimes
- ❑ Not very often
- ❑ No, not at all

***8. I have felt sad or miserable**
- ❑ Yes, most of the time
- ❑ Yes, quite often
- ❑ Not very often
- ❑ No, not at all

***9. I have been so unhappy that I have been crying**
- ❑ Yes, most of the time
- ❑ Yes, quite often
- ❑ Only occasionally
- ❑ No, never

***10. The thought of harming myself has occurred to me**
- ❑ Yes, quite often
- ❑ Sometimes
- ❑ Hardly ever

*Source: Cox JL, Holden JM, Sagovsky R. Detection of postnatal depression: development of the 10-item Edinburgh Postnatal Depression Scale.

*Br J Psychiatry*. 1987;150:782-786.

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