

# PRENATAL HISTORY QUESTIONNAIRE

Date: \_\_\_\_\_ Name: \_\_\_\_\_ Age: \_\_\_\_\_

Occupation: \_\_\_\_\_ Education (highest completed): \_\_\_\_\_

Religion: \_\_\_\_\_ Marital Status:  S  M  D  Sep

Father of Baby: \_\_\_\_\_

Contact Number (Best #): \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

The following questions will help in the care of your pregnancy. Please answer these questions as well as you can. If you need help answering the questions, please ask your health care provider. The first questions relate to you. The next set of questions will be about you, your baby's father, and both your families. When thinking about your families, please include your child (or unborn baby), mother, father, sisters, brothers, grandparents, aunts, uncles, nieces, nephews, or cousins.

## YOUR MEDICAL HISTORY

1. How old were you when you first started having periods? ..... Age: \_\_\_\_\_

2. Are your periods.....  Regular  Irregular

3. How often do your periods come? ..... Days: \_\_\_\_\_

4. How long do your periods last?..... Days: \_\_\_\_\_

5. Have you had any abnormal Pap smears? .....  Yes  No

6. Did it take you more than 1 year to get pregnant? .....  Yes  No

7. Have you ever been treated for infertility?.....  Yes  No

8. Do you have any known abnormality or anomaly of your uterus?.....  Yes  No

9. Have you had a surgical procedure on your cervix (example: LOOP, LEETZ or cone biopsy)? .....  Yes  No

10. Did your mother use DES when she was pregnant with you? .....  Yes  No

11. Have you used birth control in the past?.....  Yes  No

If yes, what type? \_\_\_\_\_

What birth control did you use in the past 90 days? \_\_\_\_\_

12. Do you have any problems with your breasts?.....  Yes  No

13. Have you ever breast fed? .....  Yes  No

14. If you have a history of any of the following conditions, please check the box next to that condition:

- |   |   |  |
|---|---|--|
| <input type="checkbox"/> Ear, nose or throat problems | <input type="checkbox"/> Urinary problems                       | <input type="checkbox"/> Operations (please list):<br>_____            |
| <input type="checkbox"/> Asthma                       | <input type="checkbox"/> Headaches                              | _____  |
| <input type="checkbox"/> TB                           | <input type="checkbox"/> Mental health (depression or anxiety)  | _____  |
| <input type="checkbox"/> Diabetes                     | <input type="checkbox"/> Muscle, joint or bone problems         | <input type="checkbox"/> Blood transfusion                             |
| <input type="checkbox"/> Thyroid disorder             | <input type="checkbox"/> Skin disorders                         | <input type="checkbox"/> Allergy to medication (please list):<br>_____ |
| <input type="checkbox"/> Heart problems               | <input type="checkbox"/> Other diseases (please list):<br>_____ | _____  |
| <input type="checkbox"/> Hepatitis                    | _____   | _____  |
| <input type="checkbox"/> Constipation/diarrhea        | _____   | <input type="checkbox"/> Miscarriages/stillbirth                       |

(continued on back)



Patient Name:

DOB:

MRN:

Clinic Location:



Patient Name:
DOB:
MRN:
Clinic Location:

Nurse Signature:
Date:

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

27. List any illnesses in your family:

If yes, please explain:

- 26. Any hereditary problems?
25. If there is a family history of any of the following conditions, please check the box next to that condition:
Sickle cell anemia
Twins
Cystic fibrosis
Neural tube defects
Hypertension
Tay Sachs
Bleeding problem
Thalassemia
Muscular Dystrophy
Diabetes Mellitus
Heart defects
Stillbirths
Mental retardation

YOUR FAMILY'S MEDICAL HISTORY

24. Are you and the baby's father related to each other by blood (i.e., cousin).....

23. Have you ever sought and/or received treatment for alcohol or drug problems?.....

22. Have you ever taken any over-the-counter, prescription, or "street" drugs during this pregnancy?.....

21. Which statement best describes your smoking status?
I have never smoked or have smoked less than 100 cigarettes in my lifetime.
I stopped smoking before I found out I was pregnant, and I am not smoking now.
I stopped smoking after I found out I was pregnant, and I am not smoking now.
I smoke some now, but have cut down on the number of cigarettes I smoke since I found out I was pregnant.
I smoke regularly now, about the same as before I found out I was pregnant.

20. Prior to your pregnancy, about how many alcoholic beverages did you usually have per occasion?
Less than once a month
Every day
At least once a week, not daily
At least once a month, not weekly

19. Prior to your pregnancy, how often did you drink alcoholic beverages?
I do not drink alcoholic beverages
I do not drink alcoholic beverages

18. Have you had any alcohol during this pregnancy?.....

17. Have you had any x-rays during this pregnancy?.....

16. Do you have any pets at home?.....

15. At any time during the first two months of your pregnancy, have you had a rash or a fever of 103° F or greater?.....