NAME:_____ DATE:_____

Tristate Ob/Gyn Prenatal Questionnaire

What was the first day of your last menstrual period? _____. Definite/Approx/Unknown

Normal amount/Duration? Yes/No

Do you get menses monthly? Yes/No *Frequency (Days) _____ *Menarche(age onset)____

On Birth control at concept? Yes/No

HOW MANY: Total times have you been pregnant? (Include this one)_____

Deliveries have you had?____ Living children?____ Miscarriages____ Abortion_____

COMPLETE THE NEXT SECTION WITH REGARD TO YOUR PREVIOUS PREGNANCIES:

DELIVERY DATE	GEST. AGE (WEEKS)	S E X	WEIGHT	HOW DELIVERED (VAGINAL OR CSECTION)	PLACE	BY WHOM	LENGTH OF LABOR	TYPE OF ANESTHESIA	Any complications? Example: Why C-section was done.

Will you be 35 yrs or older when this baby is born? Yes/no

Do you smoke cigarettes? Yes/no If yes how many per day? _____

Do you drink alcohol? Yes/no How often?_____ Amount? _____

Have you used any "street drugs"? _____ List them:_____

Since you became pregnant, have you taken any prescription or over-the-counter

Medication? Yes/no List them with dosage and frequency:_____

_____

Are you taking a prenatal vitamin? Yes/no Are you taking any additional vitamins, supplements, or herbal supplements? Yes/no List them:_____

_____

Have you ever been treated for a sexually transmitted disease? Yes/no List them:_____

_____

Have you ever had a blood transfusion? Yes/no Have you ever been screened for cystic fibrosis? Yes/no
Result: _____.

Have you or the baby's father ever been screened for any of the following?

Sickle cell anemia: yes/no Thalassemia: yes/no Tay Sachs: yes/no

PLEASE REVIEW THE FOLLOWING HEALTH HISTORY. MAKE ANY NECESSARY COMMENTS.

PAST MEDICAL HISTORY	YES/NO	COMMENTS
Lung Disease (including asthma)	Yes/no	
Heart Disease	Yes/no	
Mitral Valve Prolapse	Yes/no	
High Blood Pressure	Yes/no	
Kidney Disease (including stones)	Yes/no	
Depression	Yes/no	
Anxiety	Yes/no	
Other Mental illness	Yes/no	
Gynecologic problems	Yes/no	
Diabetes	Yes/no	
Thyroid Disease	Yes/no	
Blood Clot	Yes/no	
Liver Disease (including Hepatitis)	Yes/no	
Gastrointestinal problems	Yes/no	
Chronic Constipation	Yes/no	
Urinary Problems	Yes/no	
Other Problems Not Listed	Yes/no	
Migraines (Chronic Headaches)	Yes/no	
Surgeries. Please list with year.		
Have you ever had MRSA?	Yes/no	

Father of the baby's First and Last name: _____

Does the father of the baby have any health problems, drink alcohol, or use

"street drugs"? Yes/no List them: _____

Has he ever fathered a child born with a birth defect? Yes/no

Any additional comments or concerns? _____

_____

Is there anything you need to disclose that was not mentioned above? (**THIS INFORMATION IS KEPT CONFIDENTIAL!**)_____

_____

The above information is true and complete to the best of my knowledge.

Date: _____Signature:_____Maiden Name: _____

EMERGENCY CONTACT NAME & PHONE NUMBER: _____