



Prenatal Questionnaire

Name: _____ Date: _____

Partner's name: _____ His contact phone: _____

First day of last menses: _____ Due Date: _____ Weeks pregnant: _____

Number of Pregnancies: _____ Full Term Deliveries: _____ Preterm Deliveries: _____ Miscarriages: _____

1. Do you consider this pregnancy to be high risk? YES NO

If yes, why? _____

2. Have you had any problems during this pregnancy? YES NO

If yes, what? _____

3. Have you had a flu shot this year? YES NO

4. Over the past 2 weeks, how often have you been bothered by any of the following problems?

	Not at all	Several days	More than 1/2 of the days	Nearly Every Day
--	------------	--------------	---------------------------	------------------

a. Little interest or pleasure in doing things	0	1	2	3
--	---	---	---	---

b. Feeling down, depressed or hopeless	0	1	2	3
--	---	---	---	---

5. Has your current partner ever threatened you or made you feel afraid? YES NO

6. Has your current partner ever hit, choked, or physically hurt you? YES NO

Previous pregnancy history: (If twins, please label)

Baby #1

Date of delivery: _____ Gender: _____ Name of baby: _____

Birth Weight: _____ Completed weeks of pregnancy: _____ Anesthesia: _____

Hospital, City, Delivering Physician: _____

Problems during delivery: _____

Vaginal, Cesarean, Vacuum, or Forceps: _____

Comments: _____

Baby #2

Date of delivery: _____ Gender: _____ Name of baby: _____

Birth Weight: _____ Completed weeks of pregnancy: _____ Anesthesia: _____

Hospital, City, Delivering Physician: _____

Problems during delivery: _____

Vaginal, Cesarean, Vacuum, or Forceps: _____

Comments: _____

Baby #3

Date of delivery: _____ Gender: _____ Name of baby: _____

Birth Weight: _____ Completed weeks of pregnancy: _____ Anesthesia: _____

Hospital, City, Delivering Physician: _____

Problems during delivery: _____

Vaginal, Cesarean, Vacuum, or Forceps: _____

Comments: _____

Genetic Screening (includes patient, baby's Father, or anyone in either family with):

- YES NO Thalessemia, Tay-Sachs, Canavan Disease, Sickle Cell Disease or Trait, Cystic Fibrosis
- YES NO Neural Tube Defect, Congenital Heart Defect, Hemophilia or other Blood Disorder
- YES NO Down Syndrome, Fragile X, Muscular Dystrophy, Huntington's Chorea, Familial Dysautonomia
- YES NO Mental Retardation, Autism or Other inherited or genetic chromosomal disorder
- YES NO Other child(ren) with birth defects
- YES NO Other: _____

Infection History

- YES NO Have you had chicken pox or the vaccination?
- YES NO Live with someone with TB or exposed to TB
- YES NO History of STD: Gonorrhea, Chlamydia, HPV, HIV, Syphilis, Trichomonas
- YES NO HIV
- YES NO Personal history of genital herpes or Partner with genital herpes
- YES NO Rash or Viral Illness since last menstrual period
- YES NO Hepatitis B, Hepatitis C
- YES NO Exposure to Zika Virus (or travel to a Zika area in the last 3 months)

Additional Comments: _____

Additional Information Pertinent To This Pregnancy

- YES NO Will you be 35 years or older at due date?
- YES NO Did you conceive by IVF?
- YES NO Do you have an abnormality of your uterus?
- YES NO Have you had a second or third trimester loss, incompetent cervix or preterm delivery?
- YES NO Do you have diabetes or a history of gestational diabetes?
- YES NO Do you own a cat? Who changes litter box? _____
- YES NO In the past year, have you been threatened, hit, slapped, or kicked by anyone you know?
- YES NO Have you used any hot tubs, saunas, or steam baths during this pregnancy?
- YES NO I am aware of the risks to myself and my baby of using alcohol, illicit or recreational drugs, and smoking during pregnancy

Pre-eclampsia Questions

- YES NO High Risk - Do you have high blood pressure or a history of high blood pressure in pregnancy or pre-eclampsia?
 - YES NO High Risk - Do you have diabetes, Kidney disease, an Autoimmune disorder such as Lupus or Rheumatoid Arthritis or Antiphospholipid Syndrome?
- Moderate Risk: Underline all that apply - BMI 30 or more First child IVF 35 or older 10 years since last child African or Afro-Caribbean ancestry Personal weight less than 6 pounds at birth Previous child less than 6 pounds at birth Abnormal first or second trimester genetic screening test

In women with risk factors, low-dose aspirin reduces the chance of developing pre-eclampsia by about 25% if started early in pregnancy, before signs of pre-eclampsia develop. This is a **preventive** medication, not a treatment for the disease. Daily low-dose aspirin is considered safe and is associated with a low likelihood of serious maternal, or fetal complications related to use. If recommended, it should be started at 12 weeks and continue until delivery.

Additional Comments: _____

For MA and MD: Height: _____ Wt: _____ BP: _____ Flu shot: _____

PHQ2 Score: _____ ASA recommended: _____