Stanford HEALTH CARE

Patient Name:

MRN:

Today's Date:_____/_____/_____

Prenatal Questionnaire

MENSTRUAL HISTORY

First day of your Last Menstrual Period (LMP) :_____ Was it normal in duration? ☐ Yes ☐ No

Do you have monthly periods? ☐ Yes ☐ No If no, how often do you have a period:_____

At what age did you have your first period: _____

CURRENT PREGNANCY

What is your height:_____ What is your weight pre-pregnancy:_____

Were you using birth control prior to finding out you were pregnant? ☐ No ☐ Yes If yes, type:_____

Will you be 35 years or older at the time of delivery? ☐ No ☐ Yes Your Ethnicity: _____

Baby's Father Name: _____ FOB Ethnicity: _____

Do you consider this pregnancy to be high risk? ☐ No ☐ Yes If yes, why? _____

Did you conceive by IVF or ART procedures? ☐ No ☐ Yes

If yes, what procedure: _____

Have you used any hot tubs, saunas, or steam bath since you found out you were pregnant? ☐ No ☐ Yes

Do you have a pediatrician? ☐ No ☐ Yes If yes, who?_____

What medications have you taken since your last menstrual period: _____

Do you desire sterilization at the time of delivery? ☐ No ☐ Yes

Are you enrolled or plan to enroll in WIC Prenatal Care Program? ☐ No ☐ Yes

PAST PREGNANCY HISTORY

TOTAL PREGNANCIES	FULL TERM	PREMATURE	ABORTIONS INDUCED	ABORTIONS SPONTANEOUS	ECTOPICS	MULTIPLE BIRTHS	LIVING

PAST PREGNANCY (LAST SIX)

DATE M/D/Y	GA WEEKS	LENGTH OF LABOR	BIRTH WEIGHT	SEX	TYPE OF DELIVERY	PLACE OF DELIVERY	COMPLICATIONS

Was any pregnancy a second or third trimester loss? ☐ No ☐ Yes

Did you deliver any pregnancy prior to 37 week's gestation? ☐ No ☐ Yes

Did you have an incompetent cervix with any pregnancy? ☐ No ☐ Yes

Did you have high blood pressure or pre-eclampsia with any pregnancy? ☐ No ☐ Yes

Did you have gestational diabetes with any pregnancy? ☐ No ☐ Yes

Was any pregnancy delivered by C-section? ☐ No ☐ Yes

Are you Rh Negative? ☐ No ☐ Yes ☐ Unsure

Today's Date:_____/_____/_____ Your name:_____ Date of Birth:_____/_____/_____

MEDICAL HISTORY *(CHECK ALL THAT APPLY)*

☐ DIABETES	☐ HYPERTENSION	☐ D (RH) SENSITIZED
☐ AUTOIMMUNE DISORDER	☐ HEART DISEASE	☐ TUBERCULOSIS
☐ KIDNEY DISEASE	☐ THYROID DYSFUNCTION	☐ DRUG ALLERGIES
☐ NEUROLOGIC/EPILEPSY	☐ ASTHMA	☐ LATEX ALLERGY
☐ PSYCHIATRIC	☐ ANXIETY	☐ BREAST IMPLANTS
☐ DEPRESSION	☐ POST PARTUM DEPRESSION	☐ GYN SURGERY
☐ HEPATITIS	☐ LIVER DISEASE	☐ HISTORY OF ABNORMAL PAP
☐ VARICOSITIES	☐ PHLEBITIS	☐ UTERINE ANOMALY
☐ SEASONAL ALLERGIES	☐ ANESTHETIC COMPLICATIONS	☐ INFERTILITY
☐ HISTORY OF BLOOD TRANSFUSIONS		☐ ART TREATMENT

OTHER NOT LISTED ABOVE: _____

SURGICAL HISTORY

SURGERY PERFORMED	MONTH/YEAR	SURGERY PERFORMED	MONTH/YEAR
☐ ABDOMINAL SUGERY		☐ MYOMECTOMY	
☐ APPENDECTOMY		☐ LAPORSCOPY	
☐ C-SECTION		☐ LEEP/CONE BIOPSY	
☐ GASTRIC BYPASS		☐ OTHER:	
☐ OTHER:		☐	

DRUG ALLERGIES

ARE YOU ALLERGIC TO LATEX? ☐ Yes ☐ No

MEDICATION	REACTION	MEDICATION	REACTION

FAMILY HISTORY

Please write any diseases/conditions present in your family:

Mother: _____ ☐ Deceased

Father: _____ ☐ Deceased

Sister: _____ ☐ Deceased

Sister: _____ ☐ Deceased

Brother: _____ ☐ Deceased

Brother: _____ ☐ Deceased

Other family members (name relationship and medical disease/condition)

_____

Today's Date:_____/_____/_____ Your name:_____ Date of Birth:_____/_____/_____

GENETIC SCREENING

Do you, the baby's father, or a member of either family, been diagnosed with the any of the following:

NO		IF YES, WHO
☐	THALASSEMIA?	☐ _____
☐	NEUTRAL TUBE DEFECT (MENINGOMYELOCELE, SPINA BIFIDA OR ANACEPHALY)?	☐ _____
☐	CONGENITAL HEART DEFECT?	☐ _____
☐	DOWN SYNDROME?	☐ _____
☐	TAY-SACHS	☐ _____
☐	CANAVAN DISEASE?	☐ _____
☐	FAMILIAL DYSAUTONOMIA?	☐ _____
☐	SICKLE CELL DISEASE OR TRAIT?	☐ _____
☐	HEMOPHILIA OR OTHER BLOOD DISORDERS?	☐ _____
☐	MUSCULAR DYSTROPHY?	☐ _____
☐	CYSTIC FIBROSIS?	☐ _____
☐	HUNTINGTON'S CHOREA?	☐ _____
☐	MENTAL RETARDATION / AUTISM?	☐ _____
☐	FRAGILE X	☐ _____
☐	OTHER INHERITED GENETIC OR CHOROMOSOMAL DISORDER?	☐ _____
☐	OTHER BIRTH DEFECT NOT LISTED ABOVE?	☐ _____

INFECTION HISTORY

Yes	No	Have you had the chicken pox or the vaccination?
Yes	No	Do you live with someone with TB or been exposed to TB?
Yes	No	Have you had a Rash or viral illness since your last period?
Yes	No	Do you have a history of Hepatitis B or C?
Yes	No	Do you have a history of HPV (Human papilloma Virus)?
Yes	No	Do you have a history of HIV (Human Immunodeficiency Virus)?
Yes	No	Do you have a history of STI (Sexual Transmitted Infection)?
Yes	No	Do you have a history of Genital Herpes?
Yes	No	Do you have a history of Gonorrhea?
Yes	No	Do you have a history of Chlamydia?
Yes	No	Do you have a history of Syphilis?
Yes	No	Does your partner have a history of genital herpes?

Over the past 2 weeks, how often have you been bothered by any of the following: *(Please circle)*

	Not at all	Several days	More than ½ the days	Nearly every day
1. little interest or pleasure in doing things	0	1	2	3
2. feeling down, depressed or hopeless	0	1	2	3

Today's Date:_____/_____/_____ Your name:_____ Date of Birth:_____/_____/_____

SOCIAL HISTORY

Do you use Tobacco? ☐ Never ☐ Current ☐ Former Type: ☐ Cigarettes ☐ E-Cigarettes

How many pack of cigarettes each day _____ Number of years smoked? _____

Do you use smokeless tobacco?: ☐ No ☐ Yes

Have you smoked since finding out you were pregnant? ☐ No ☐ Yes

Is there passive smoke exposure? ☐ No ☐ Yes

Do you drink Alcohol? ☐ Never ☐ Daily ☐ Socially Drinks per week_____

Have you drank alcohol since finding out you were pregnant? ☐ No ☐ Yes

Do you use Recreational Drugs? ☐ No ☐ Yes

If yes, which type? ☐ Methamphetamine ☐ Ecstasy ☐ Heroin ☐ Cocaine IV ☐ Prescription Drugs

Have you used recreational drugs since finding out you were pregnant? ☐ No ☐ Yes

Do you exercise? ☐ No ☐ Yes How often _____days/week for how long: _____

What type of exercise: _____

Has your current partner ever threaten you or made you feel afraid? ☐ No ☐ Yes

Has your current partner ever hit, choked or physically hurt you? ☐ No ☐ Yes

Are there cats in the home? ☐ No ☐ Yes If yes, who changes the litter box? _____

Do you wear your seatbelt frequently? ☐ No ☐ Yes

Are there firearms in the home? ☐ No ☐ Yes

Are there smoke detectors in the home? ☐ No ☐ Yes

Are there carbon monoxide detectors in the home? ☐ No ☐ Yes

----------Clinic Use Only----------

Weight _____ MD order ☐ PN Labs

Blood Pressure _____/_____

EDD by LMP _____ U/S EDD _____