Stanford HEALTH CARE

Patient Name:

DOB/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, 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, type:_____

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

Baby's Father Name: _____ FOB Ethnicity: _____

Do you consider this pregnancy to be high risk? ☐ No ☐ 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, who?_____

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

Do you desire reproductive sterilization (permanent birth control) with this pregnancy/delivery? ☐ No ☐ Yes

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

PAST PREGNANCY HISTORY

# OF TOTAL PREGNANCIES	# FULL TERM DELIVERY	# PREMATURE DELIVERY	# ABORTIONS INDUCED	# ABORTIONS SPONTANEOUS	# ECTOPICS	# MULTIPLE BIRTHS	# LIVING CHILDREN

PAST PREGNANCY (LAST SIX)

DATE M/D/Y	GA WEEKS	LENGTH OF LABOR	BIRTH WEIGHT	SEX	TYPE OF DELIVERY	DELIVERY LOCATION	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 blood type? ☐ No ☐ Yes ☐ Unsure

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MEDICAL HISTORY *(CHECK ALL THAT APPLY)*

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

OTHER NOT LISTED ABOVE: _____

SURGICAL HISTORY ☐ None

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

DRUG ALLERGIES ☐ None

ARE YOU ALLERGIC TO LATEX? ☐ No ☐ Yes, REACTION:_____ **PEANUTS?** ☐ No ☐ Yes, REACTION:_____

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:_____/_____/_____

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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?	☐ _____
☐	AUTISM OR MENTAL RETARDATION?	☐ _____
☐	FRAGILE X?	☐ _____
☐	OTHER INHERITED GENETIC OR CHOROMOSOMAL DISORDER?	☐ _____
☐	HAVE OTHER CHILD(REN) WITH BIRTH DEFECTS?	☐ _____
☐	OTHER BIRTH DEFECT NOT LISTED ABOVE?	☐ _____

INFECTION HISTORY

Yes	No	
○	○	Do you live with someone with TB or been exposed to TB?
○	○	Do you have a history of Gonorrhea?
○	○	Do you have a history of Chlamydia?
○	○	Do you have a history of HPV (Human papilloma Virus)?
○	○	Do you have a history of Syphilis?
○	○	Do you have a history of Trichomonas?
○	○	Do you have a history of HIV (Human Immunodeficiency Virus)?
◉	○	Do you have a history of Genital Herpes?
◉	○	Does your partner have a history of genital herpes?
◉	○	Have you had a skin rash or viral illness since your last period?
○	○	Do you have a history of Hepatitis B or C?

Chicken Pox (Varicella) Status: ☐ Unknown ☐ Immunized ☐ Had disease ☐ Immune ☐ Negative

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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

SOCIAL HISTORY

Tobacco Use ☐ Never ☐ Current ☐ Former year quit:_____

Please answer additional questions for current or former user

Type: ☐ Cigarettes ☐ Pipe ☐ Cigars

How many packs/per day _____ Number of yrs smoked _____

Smokeless Tobacco Use ☐ Never ☐ Current ☐ Former year quit:_____

Type: ☐ Snuff ☐ Chew

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

Is there passive smoke exposure (someone in the home environment that smokes)? ☐ No ☐ Yes

Alcohol Use ☐ Never ☐ Daily ☐ Socially Drinks per week:_____

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

Recreational Drug Use ☐ Never ☐ Current ☐ Former year quit:_____

Please answer additional questions for current or former user

Type: ☐ Marijuana ☐ Methamphetamine ☐ Ecstasy ☐ Heroin

☐ Cocaine ☐ IV ☐ Prescription Drugs ☐ Other:_____

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

E-Cigarette Use ☐ Never ☐ Current ☐ Former year quit:_____

Are you planning to breast feed? ☑ No ☐ Yes ☐ Undecided

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, who changes the litter box? _____

Do you wear your seatbelt frequently? ☐ No ☐ Yes

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

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

Have you ever been tested for Cystic Fibrosis (CF), Fragile X or Spinal Muscular Atrophy (SMA)? ☐ Yes ☐ No

Race and Ethnicity is required for Prenatal Screening Testing and Genetic Carrier Screening Testing. To help make sure we have the correct Race and Ethnicity,

Please check or circle all ethnicities (ancestry) that you identify yourself as:

- ☐ **Japanese**
- ☐ **Chinese or Taiwanese**
- ☐ **Korean**
- ☐ **Filipino**
- ☐ **Vietnamese**
- ☐ **Cambodian**
- ☐ **Lao**
- ☐ **Native America**
- ☐ **Black**
- ☐ **Hawaiian**
- ☐ **Guamanian**
- ☐ **Samoan**

☐ **Other Southeast Asian**- Malaysia, Indonesia, Thailand, Burma (Myanmar), Hmong, or Lahu

☐ **Hispanic**- Mexico, Central America, South America (all languages), Puerto Rico, Cuba or Dominican Republic

☐ **White**- European countries including Spain, Portugal, Russia. May also include those of Jewish descent.

☐ **Middle Eastern**-Afghanistan, Armenia, Azerbaijan, Bahrain, Egypt, other North African Countries, Iran, Iraq, Israel, Jordan, Kazakhstan, Kuwait, Kyrgyzstan, Lebanon, Oman, Palestine, Qatar, Saudi Arabia, Syria, Tajikistan, Turkey, Turkmenistan, United Arab Emirates or Yemen.

☐ **Indian Subcontinent**-Pakistan, India, Sri Lanka, Nepal, Bangladesh or Fijian

☐ **Other**- Other Pacific Islander, Eskimo/Native Inuit, Native Alaskan, Tongan, Mongolian, Mian/Mien, Tibetan, Fijian

☐ **Other not listed**: _____