Welcome to our practice!

Dear Patient:

Congratulations! Thank you for selecting our practice for your obstetrical care. Our physicians are committed to helping you to have a happy, healthy pregnancy and delivery.

Our group consists of both male and female obstetricians and a nurse practitioner that share common philosophies and strive for the same quality of excellence.

When the day of your delivery arrives, if it is not possible for your own physician to be present, one of our other highly trained obstetricians will be on call to give you excellent patient-centered care with attention to your wishes. At that time, we will be unable to give you a choice of a male or female physician but be assured that each of our physicians shares the same commitment to you and your baby!

We understand what a special time this is in your life. You and your baby are special to each and every one of us. We will make every effort to ensure that you receive the best medical and personal care possible during your pregnancy and delivery.

Welcome to our family!

Sincerely,

Jennifer Adey, M.D.
Danielle Beharie, D.O.
Scott Eaton, M.D.
William Phillips, M.D.
Rebecca Stone, M.D.

My signature below indicates that I have read the above statement. I acknowledge and understand that my physician may not be available at the time of my delivery and another physician will deliver me.

Patient Signature _____ Date _____

Stanford HEALTH CARE

Label

Prenatal Questionnaire

Although we may have much of the information that we are asking for in this form, the initial visit of prenatal care is a most important time for both of us to thoroughly review your medical history and current health.

Today's Date:_____

Preferred Name: _____ Age:_____

Clinic use: GA_____ EDD_____

MENSTRUAL STATUS

First day of your Last Menstrual Period (LMP) :_____ Was it normal in duration?

CURRENT PREGNANCY

Is this your first pregnancy? What was your last weight? _____

Were you using birth control at the time you got pregnant? _____

Do you consider this pregnancy to be high risk? _____

Did you conceive by IVF or ART procedures? Was Egg donor used? ___

If yes, what procedure: _____

Do you desire reproductive sterilization (permanent birth control) with this pregnancy/delivery?

Have you traveled to any countries with Zika Virus (southern hemisphere) in the 6 months prior to pregnancy?

PAST PREGNANCY HISTORY *(SKIP THIS SECTION IF THIS IS YOUR FIRST PREGNANCY)*

# OF TOTAL PREGNANCIES	# FULL TERM DELIVERY	# PREMATURE DELIVERY	# ABORTIONS	# MISCARRIAGES	# ECTOPICS	# LIVING CHILDREN

Was any pregnancy a second or third trimester loss?

Did you deliver any pregnancy prior to 37 week's gestation?

Did you have an incompetent cervix with any pregnancy?

Did you have high blood pressure or pre-eclampsia with any pregnancy?

Did you have gestational diabetes with any pregnancy?

Was any pregnancy delivered by C-section?

Was any child born less than 6 pounds or more than 10lbs at birth?

Are you Rh Negative blood type?

PAST PREGNANCY DETAIL *(DELIVERY TYPE IS VAGINAL, CESAREAN, ABORTION, MISCARRIAGE, ECTOPIC)*

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

MENTAL HEALTH HISTORY AND SCREENING

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

1. little interest or pleasure in doing things
2. feeling down, depressed or hopeless

Have you ever been diagnosed or treated for anxiety?
Have you ever been diagnosed or treated for depression?

PREVENTATIVE HISTORY

	No	Yes	Date
Have you had a flu shot this year?			
Did you receive the Covid-19 vaccine?			

Which one?_____

Date of last pap smear: _____

Date of last mammogram (over age 40 only):_____

MEDICATION ALLERGIES ☐None

PLEASE WRITE ANY MEDICATION ALLERGY YOU HAVE HAD AND INCLUDE REACTION:

DO YOU HAVE A NUT ALLERGY? REACTION:_____

MEDICATIONS

Please list any prescribed medications you are taking or have taken since your last period: ☐ None

Medication Name	Dose/Strength	How do you take it?

Please list any non-prescribed or over the counter medications you are taking: ☐None

MEDICAL HISTORY

PLEASE WRITE IN ANY MEDICAL CONDITIONS YOU HAVE OR HAVE HAD: ☐ None

Do you have diabetes, kidney disease or an autoimmune disease?
Did you weigh less than 6 pounds at birth?

PLEASE WRITE IN ANY GYNECOLOGICAL CONDITIONS YOU HAVE OR HAVE HAD: ☐ None

Do you have an abnormality of your uterus? , if Yes, what kind?_____
Age you had your first period:_____

PLEASE WRITE IN ANY SURGERY YOU HAVE HAD (*PLEASE INCLUDE MONTH/YEAR*): ☐ None

SOCIAL HISTORY

What is your occupation? _____

What is the name of your partner/spouse? _____

Have you smoked since finding out you were pregnant?
Is there passive smoke exposure (someone in the home environment that smokes)?
Have you drank alcohol since finding out you were pregnant?
Have you used recreational drugs since finding out you were pregnant?

Do you currently use tobacco products? Are you ready to quit?

How often do you use:

Tobacco?	Type:_____	year quit: _____
E-Cigarette/Vape?		year quit: _____
Smokeless Tobacco?		year quit: _____
Alcohol?		year quit: _____
Recreational Drugs?	Type: _____	year quit: _____
Marijuana?		

Have you been hit, kicked, punched, or otherwise hurt by someone in the past year?
Do you feel safe in your current relationship?
Is there a partner from a previous relationship who is making you feel unsafe now?

Label

Do you exercise? , How often _____days/week

What type of exercise: _____ for how long: _____

Are there cats in the home?
If yes, who changes the litter box? _____

Do you follow a specific nutrition/food plan: :_____

FAMILY HISTORY

Please write list immediate family members (1st degree) who have:

Breast Cancer _____ Colon Cancer _____

Ovarian Cancer _____ Other Cancer _____

PLEASE PROIVDE DETAIL AS APPLICABLE

Relationship	Name	Status/Age	List any/all Medical Conditions
Mother			
Father			
Sister			
Brother			
Maternal Grandmother			
Maternal Grandfather			
Paternal Grandmother			
Paternal Grandfather			
Other			
Other			

INFECTION HISTORY

- 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:

PRENATAL GENETIC SCREENING

PLEASE ANSWER ALL QUESTIONS:

Will you be 35 years or older when the baby is due?
Have you been previously tested for SMA, Fragile X or Cystic Fibrosis?
What was the result: _____
Do you have a BMI of 30 or more?
Have you or the baby's father had three or more first trimester miscarriages?
Are you and the baby's father related in any way?

Have you, the baby's father, or anyone in either family ever had any one of the following disorders:

	If Yes, who
Thalassemia	_____
Neutral tube defect, Spina Bifida or Anencephaly?	_____
Congenital Heart Defect?	_____
Down Syndrome?	_____
Tay-Sachs?	_____
Canavan Disease?	_____
Familial Dysautonomia?	_____
Sickle cell disease or Trait?	_____
Hemophilia or other blood Disorder?	_____
Muscular Dystrophy?	_____
Cystic Fibrosis?	_____
Huntington's Chorea?	_____
Autism or Mental Retardation?	_____
Fragile X?	_____
Any other Genetic or Chromosomal Disorder?	_____
Have other children with birth defects?	_____
Have any other birth defect not listed above?	_____

Do you have any concerns you would like to discuss today?

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**: _____