PREGNANCY CARE HISTORY

Please answer the following questions so we may focus on your individual pregnancy health issues.

Name: ______________________________ **DOB:** ______________

Menstrual History

1. What was the first day of your last period? ______________

Yes No 2. Did you get pregnant using fertility medications, artificial insemination or in vitro fertilization? **If yes please circle which Procedure you had**

3. How frequent are your periods? (For example - every 28 days) ______________

Pregnancy Test

Yes No 4. Did you have a positive pregnancy test?
If yes, Urine test or blood test? ______________

5. What was the date of the positive pregnancy test? ______________

Pap

6. When was the date of your last pap smear? The result was: ______________

Current Condition

Yes No 7. Are you having any symptoms since your last period such as excessive nausea, vomiting, vaginal bleeding, abdominal pain or any other problem?
If yes, please list your symptoms: ______________

____

Yes No 8. Are you taking prenatal vitamins?

Yes No 9. Have you gained or lost weight? **If yes**, how much? ______________

Significant Medical History

Yes No 10. Is this your first pregnancy? **If no**, any previous complications?

____

11. Please list all medications with doses taken since your last period.
(Include vitamins, supplements, over the counter medications)

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Social History

Yes No 12. Do you smoke? **<u>If yes</u>**, how many cigarettes per day? ____________________
For how long? ____________________

Yes No 13. Have you consumed alcohol since your last period?
<u>If yes</u>, how much? ____________ For how long? ____________
When was your last drink? ____________________

Yes No 14. Have you used any drugs? **<u>If yes</u>**, what type of drugs and how frequent? ____________________

Yes No 15. Is the father of your baby supportive of the pregnancy?

Yes No 16. If your family supportive of the pregnancy?

Other Risk Factors

Yes No 17. Would you accept a blood transfusion in a life-threatening situation?

Yes No 18. Do you have any cats? **<u>If yes</u>**, are they indoor and/or outdoor cats? ____________

Yes No 19. Do you have close contact with children not related to you on a regular basis?

Yes No 20. Have you ever had chickenpox?

Yes No 21. Have you ever had any domestic violence issues?

Yes No 22. Will you be 35 years or older when you deliver?
<u>If yes</u>, what age will you be? ____________

Yes No 23. Have you been exposed to any chemicals, gases, radiation or x-rays in your home or environment?

Have you, the father of the baby or any other family member every had any of the following?

Yes No Ashkenazi Jewish background?
Yes No Thalassemia (Italian, Greek, Mediterranean, Asian background)?
Yes No Tay-Sach's disease (Jewish, Cajun, French Canadian)?
Yes No Canavan's disease?
Yes No Cystic Fibrosis?
Yes No Sickle cell disease or trait?
Yes No Neural tube defects such as spina bifida or anencephaly?
Yes No Birth defect of the heart?
Yes No Any other birth defect?
Yes No Hemophilia or bleeding disorder?
Yes No Muscular dystrophy?
Yes No Huntington's chorea?
Yes No Down's syndrome?
Yes No Mental retardation or autism?
Yes No Genetic or chromosome disorder?
Yes No Diabetes requiring insulin?
Yes No PKU (phenylketonuria)?
Yes No Stillborn baby or more than 1 miscarriage?

Infection History

Yes No Have you been exposed to TB?
Yes No Have you or your partner ever had genital herpes?
Yes No Have you had any rashes or illnesses since your last period?
Yes No Have you ever had an STD - Gonorrhea, Chlamydia, Syphilis, HPV, Genital warts, HIV?
Yes No Have you ever had Hepatitis B or C?
Yes No Have you had any other infectious diseases?