PREGNANCY QUESTIONAIRE

**Welcome to our practice. Please fill this questionnaire as thoroughly as possible and bring it with you at the time of your appointment. Please remember to bring with you any pertinent insurance information. We look forward to seeing you.*

The name by which you would like to be called: ______________________________
Full Name: ______________________________ Date: ______________
Age: ________Date of birth: ______________ Place of birth: ______________
Home Address: ______________________________
Home Phone: ____________ Business Address: ______________________________
Business Phone: ______________________ Occupation: ______________
Who may we contact in case of an emergency? ______________ Phone: ______________
How did you hear about our practice? ______________________________

OBSTETRICAL HISTORY

Total # of pregnancies including the present one: _____# of deliveries before 37 weeks: _____ Miscarriages: _____
Abortions: _____ Tubal pregnancies: _____ Multiple births: _____ Stillbirths: _____ Living children: _____
When did your last period start? __________When did your previous period start? __________
Number of days between periods? __________ How long are your periods? __________
Do you have bleeding between periods? ☐ Yes ☐ No Bleeding since last period? ☐ Yes ☐ No
Most recent birth control method? ______________ Duration of use: ______________
When did you last use contraception? ______________ Date of last pap smear? ______________
Have you ever had an abnormal PAP smear? ☐ Yes ☐ No If Yes, when? ________ How was it treated? ________
Have you ever been treated for infertility? ☐ Yes ☐ No If Yes, how? ______________________
Have you recently had a positive pregnancy test? ☐ Yes ☐ No If Yes, when? ________ Where? ________

List pregnancies in order including miscarriages, abortions, stillbirths and tubal.

Date	Hospital	Delivery Method	Weeks	Hours of Labor	Weight	Complications	Name

Have you had any difficult vaginal deliveries? ☐ Yes ☐ No
Have you carried pregnancies with any birth defects? ☐ Yes ☐ No

Please check if you have had any of the following (include dates, if known):

☐ Diabetes	☐ Cancer	☐ Free-bleeding	☐ Hypertension
☐ Kidney stones	☐ Anemia (low blood count)	☐ Heart murmur	☐ Mental health problems
☐ Sickle cell screening	☐ Irregular heartbeat	☐ Nausea/vomiting	☐ Negative blood type
☐ Chest pains	☐ Breast disease	☐ Asthma	☐ Shortness of breath
☐ More than 2 preg. losses	☐ Visual problems	☐ Heart surgery	☐ Hepatitis/liver disease
☐ Headaches	☐ Rheumatic fever	☐ Varicose veins/blood clots in legs	☐ Dental problems
☐ Mitral valve prolapse	☐ Thyroid disease	☐ Bowel problems	☐ Accidents/injuries
☐ Bladder/kidney infections	☐ Uterine fibroid tumors	☐ Seizures	☐ Blood transfusions
☐ Gallbladder disease	☐ Removal of skin moles	☐ Phenylketonuria	☐ Hepatitis/liver disease

Have you had a rash or viral illness since your last period? ☐ Yes ☐ No
Any allergies to medications or soaps such as Betadine? ☐ Yes ☐ No
Have you been instructed in performing a breast-self exam? ☐ Yes ☐ No

Please check if you have had any of the following (include date and treatment, if known):

☐ Hepatitis	☐ Gonorrhea	☐ Tuberculosis	☐ Polio	☐ Herpes simplex	☐ Chlamydia
☐ Syphilis	☐ Venereal warts	☐ German measles			

Have you been immunized for the following (include date of immunization, if known)?
☐ Hepatitis ______ ☐ Rubella ______ ☐ Tetanus ______ ☐ Tuberculosis ______

List any operations, when they were done, why they were done, and any complications: ________________________________
____

Have you had any problems after having anesthesia for surgery? ☐ Yes ☐ No

List members of your immediate family (parents, brothers, sisters, children) with:

	Relative (sister, uncle, etc.)	Maternal side	Paternal side	Age at Diagnosis	Deceased from this cancer? If yes, at what age?	Age Now
Cancer						
Bleeding Disorder						
Tuberculosis						
Birth Defects						
Diabetes						
Heart Disease						
Neurological Disorder						
Glaucoma						
Sickle Cell						
Muscular Dystrophy						
Huntington Disease						
Mental Retardation						
Ashkenazi (Eastern European Jewish)						
Cystic Fibrosis						
Other						

Please check your marital status: ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed
State your husbands name: ____________________ Age: __________

Which medications are you taking normally (include over-the-counter and their dosages)?

Date started	Medication & Dose	Directions	Reason for Taking	Prescribed by

List any medications taken since your last period.

Date started	Medication & Dose	Directions	Reason for Taking	Prescribed by

Have you ever been exposed to any x-rays since your last period? ☐ Yes ☐ No
When was your last tuberculosis test? _______________ What was the result? ____________
Do you work with farm animals, have cats as pets, or eat raw or uncooked meat of any kind? ☐ Yes ☐ No
How many times each week do you exercise? _______________ Do you use a hot tub or sauna? ☐ Yes ☐ No
Does your house have lead pipes? ☐ Yes ☐ No
Do you currently smoke? ☐ Yes ☐ No How many cigarettes per day do you smoke? ____ How many years? _____

Are you a former smoker? ☐ Yes ☐ No If Yes, # of cigarettes per day?____ # of years? _____ Date you quit? ______
Do you drink alcohol? ☐ Yes ☐ No If Yes, how often? ☐ monthly or less ☐ 2-4 times/month ☐ 2-3 times/week ☐ 4 or more
How much weight have you gained or lost in the last year? ________________

List all non-prescription drugs, herbs or supplements.

Date started	Medication & Dose	Directions	Reason for Taking	Prescribed by

To which countries do you travel? ____
Do you have any physical limitations or needs? ____
Are you currently under the care of any other physicians? ☐ Yes ☐ No
Are there any issues you wish to discuss not previously mentioned? ____

**Thank you for your patience filling out this questionnaire. The information will be kept in the strictest confidence.*