



MRN: _____

Division 22
 Drs. Band, Sine, Resta, Lizardo, Shrout, Lin, Rose

New Pregnancy Questionnaire

Today's Date: _____

Patient Name: _____ Date of Birth: _____
 Last, First, MI

Religion: _____ Place of Birth: _____

Currently Pregnant: Yes No If yes, name of partner: _____

***Last Menstrual Period _____

Name of Pharmacy: _____

Office use: HT _____ WT _____ BP: _____

Pharmacy Phone: _____

Primary Care Provider: _____ ➔

Pharmacy Address: _____

Current Medications

Drug	Dosage

Allergies

Type of Allergy	Reaction

Past Obstetrical History

Full Term: _____ Premature: _____ Abortion: _____ Miscarriages: _____ Living Children: _____

No.	Date	Sex	Weight	Duration Of Labor	Type Of Delivery	Anesthesia	Complications

GYN History

<u>GYN History</u>	<u>Year</u>	<u>Result</u>	<u>Treatment</u>
Abnormal Pap			
Other GYN Problems			
STD History			

Other Past Medical History

<u>Date</u>	<u>Problem/Disease</u>

Family History of Disease

(Include any history of breast cancer, ovarian cancer, or abnormal blood clots)

<u>Family Member</u>	<u>Problem/Disease</u>	<u>Age at Diagnosis</u>

Social History

<u>Test/Procedure</u>	<u>Pap</u>	<u>Mammogram</u>	<u>Bone Density</u>	<u>Colonoscopy</u>
<u>Year</u>				
<u>Result</u>				

<u>Current</u>	<u>Tobacco</u>	<u>Alcohol</u>	<u>Caffeine</u>
<u>Type:</u>			
<u>Amount:</u>			
<u>Year Stopped:</u>			

Do you feel safe in your current environment? YES NO

Are you experiencing and problems with urinary incontinence? YES NO

GENETIC COUNSELING: Please circle YES if you or your baby's father have a family history (blood relative) of any of the following, or if either you have the following background:

- | | | |
|---|-----|----|
| 1. Patient's age of 35 years or older as of estimated date of delivery | Yes | No |
| 2. Thalassemia (Italian, Greek, Mediterranean or Asian background) | Yes | No |
| 3. Neural Tube Defects (meningomyelocele, spina bifida or anencephaly) | Yes | No |
| 4. Congenital heart defect | Yes | No |
| 5. Down Syndrome | Yes | No |
| 6. Tay Sachs (Ashkenazi Jewish, Cajun, French Canadian) | Yes | No |
| 7. Canavan Disease (Ashkenazi Jewish) | Yes | No |
| 8. Familial dysautonomia (Ashkenazi Jewish) | Yes | No |
| 9. Sickle Cell disease or trait (African) | Yes | No |
| 10. Hemophilia or other blood disorders | Yes | No |
| 11. Muscular dystrophy | Yes | No |
| 12. Cystic fibrosis | Yes | No |
| 13. Huntington's chorea | Yes | No |
| 14. Mental retardation/autism | Yes | No |
| 15. Other inherited genetic or chromosomal disorder | Yes | No |
| 16. Maternal metabolic disorder (e.g., Type 1 Diabetes, PKU) | Yes | No |
| 17. Patient or baby's father had a child with birth defects not listed above | Yes | No |
| 18. Recurrent pregnancy loss or a stillbirth | Yes | No |
| 19. Medications (including supplements, vitamins, herbs, or OTC drugs/ Illicit/rec. drugs/alcohol since last menstrual period | Yes | No |

If yes, agent and strength/dosage: _____

X _____
Signature of patient or guardian of minor

Continue to next page 

Medical History (Please Circle)

1. Diabetes	Yes	No	16. Varicella (chicken pox)	Yes	No
2. Hypertension	Yes	No	17. Pulmonary (TB, Asthma)	Yes	No
3. Heart Disease	Yes	No	18. Seasonal allergies	Yes	No
4. Autoimmune Disorder	Yes	No	19. Drug/Latex Allergies	Yes	No
5. Kidney Disease/UTI	Yes	No	20. Breast Problems	Yes	No
6. Neurologic/epilepsy	Yes	No	21. GYN surgery	Yes	No
7. Psychiatric	Yes	No	22. Operation/hospitalization	Yes	No
8. Depression/postpartum	Yes	No	23. Anesthetic complications	Yes	No
9. Hepatitis/liver disease	Yes	No	24. History of abnormal PAP	Yes	No
10. Varicosities/phlebitis/ blood clots	Yes	No	25. Uterine Anomaly	Yes	No
11. Thyroid dysfunction	Yes	No	26. Infertility	Yes	No
12. Trauma/violence	Yes	No	27. ART Treatment	Yes	No
13. Blood transfusions	Yes	No	28. Relevant History	Yes	No
14. Would you accept a blood transfusion?	Yes	No	29. Cats (as pets)	Yes	No
15. 15 D (Rh) sensitive	Yes	No	30. HPV Vaccine	Yes	No

Date Completed _____

According to the Center for Disease Control (CDC) guidelines, ZIKA testing is recommended for symptomatic pregnant women or those with ongoing travel to a ZIKA active area. If you have traveled to a ZIKA active area and are asymptomatic, you can still be tested, however, it will go through your private insurance plan.

If you or your partner have traveled outside of the United States **during this pregnancy**, please list below.

1. _____ Date of travel _____

2. _____ Date of travel _____

Signature _____ Date: _____

I understand by *declining*** Zika testing, early detection of fetal abnormalities may be undiagnosed as a result.

Signature _____ Date: _____