MRN:

CAPITAL WOMEN'S CARE

Division 22
Drs. Sine, Lin, Footer, Wagar, Vignali, Lefkof NP

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**__________________________ Patient Phone #__________________

Name of Pharmacy:______________________________ Office use: HT_________WT________BP:___________

Pharmacy Phone:_______________________________ **Primary Care Provider:**____________________________

Pharmacy Address:_____________________________ **Planned of feeding: Breast Bottle Both**

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

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GYN History

GYN History	Year	Result	Treatment
Abnormal Pap			
Other GYN Problems			
STD History			

Other Past Medical History

Date	Problem/Disease

Family History of Disease

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

Family Member	Problem/Disease	Age at Diagnosis

Social History

Test/Procedure	Pap	Mammogram	Bone Density	Colonoscopy
Year				
Result				

Current	Tobacco	Alcohol	Caffeine
Type:			
Amount:			
Year Stopped:			

Do you feel safe in your current environment? YES NO

Are you experiencing and problems with urinary incontinence? YES NO

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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

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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 *<u>declining</u>*** Zika testing, early detection of fetal abnormalities may be undiagnosed as a result.

Signature_______________________Date:__________________