

M A G N O L I A

– O B / G Y N –

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Prenatal Questionnaire

Name: _____ DOB: _____ Date: _____

Race: Caucasian Black Latin Asian Other: _____

Marital Status: Married Single Separated Divorced Widowed

Father of Baby: _____ Age: _____ Race: _____

Are you employed? Yes No If yes, who is your employer? _____

What is your highest level of education? _____ Primary Language: _____

Have you recently traveled? _____ If yes where _____

MENSTRUAL HISTORY

What is the first day of your last menstrual period? ____/____/____ Definite Estimate Unknown

How often are your periods? _____ How long do your periods last? _____

How old were you when you started having periods? ____ Were you on birth control when you got pregnant? _____

Date of first positive pregnancy test? ____/____/____ Have you had any significant pain? Yes No

Any bleeding since your positive pregnancy test? Yes No What symptoms are you having? Weight Gain

Nausea Vomiting Breast Tenderness Urinary Frequency Pelvic Pressure

Other: _____

PAST PREGNANCY

How many times have you been pregnant? _____ How many full term deliveries have you had? _____

How many premature pregnancies (before 37 weeks) have you had? _____ How many miscarriages? _____

Have you ever had twins or triplets? _____ How many living children do you have? _____

Date MO/YR	How Many Weeks Pregnant	Birth Wt	M/F	Vaginal/ C-section	Premature Labor	Any Problems with delivery or baby?

PERSONAL MEDICAL HISTORY

Do you or did you ever have any of the following medical problems?	Yes	No
Diabetes		
Hypertension		
Heart Disease		
Autoimmune Disorder		
Kidney Disease/Frequent Urinary Tract Infections		
Seizures/Epilepsy		
Migraine Headaches		
Psychiatric Disorder		
Depression		
Hepatitis/Liver Disease		
Varicose Veins		
Phlebitis/Blood Clots in Legs or Lungs		
Thyroid Problems		
Rh Blood Negative Factor		
Lung Problems (Asthma)		
Seasonal Allergies		

Do you smoke? Yes No How much per day? _____ How long have you smoked for? _____

Do you drink alcohol? Yes No How often do you drink? _____

Do you use any street drugs? Yes No Marijuana Cocaine/Crack Pills (list All) _____

Do you have any problems with violence or abuse? Yes No

Do you have a Primary Care Provider? _____

Latex Allergy? Yes No Have you ever had a history of MRSA? _____

Have you ever been diagnosed with any of the gynecological problems listed below?

Ovarian Cysts Fibroids Abnormal Uterine bleeding Polycystic ovaries Uterine abnormalities

DES Exposure Other: _____

Have you ever been evaluated for infertility? Yes No Have you ever had an abnormal pap smear? Yes No

Have you ever had any surgeries? Please list: _____ History of MRSA? Yes No

Date: _____ Surgery: _____

Date: _____ Surgery: _____

Date: _____ Surgery: _____

Have you ever had any biopsies? Yes No Have you ever had any problems with anesthesia? Yes No

Have you ever been hospitalized overnight? Yes No If yes, why? _____

YOUR FAMILY MEDICAL HISTORY

Has anyone in your family been diagnosed with the following? (Parents, Grandparents, Siblings, Children)	Yes	NO
Diabetes		
Heart Attack/Heart Disease		
Stroke/Blood Clots		
High Blood Pressure		
Cancer (breast, uterine, ovarian, colon)		
Autoimmune Disease		
Thyroid Disorder		
Psychiatric Disorder		

GENETIC HISTORY

Has anyone in your family or the father of the baby's family ever had the following?	Yes	No
Anemia/Blood Disorders		
Italian, Greek or Mediterranean Decent		
Spina Bifida		
Tay-Sachs		
Jewish, French Canadian, or Cajun		
Canavan's Disease		
Sickle Cell Anemia		
African American		
Hemophilia/Free Bladder		
Muscular Dystrophy		
Cystic Fibrosis		
Huntingdon's Chorea		
Mental Retardation/Autism		
Fragile X Syndrome		
Inherited or Chromosomal Disorders		
Metabolic Disorders (PKU)		
Cleft Lip/Palate		
Deafness or Blindness at Birth		
Birth Defects		

Will you be 35 or older when you deliver? Yes No

Have you or the father of the baby ever had any children with birth defects? Yes No

Do you have recurrent miscarriages or have you ever had a stillbirth? Yes No

Are you interested in learning more about Cord Blood Banking ? _____

INFECTION HISTORY

Have you ever been exposed to Tuberculosis or ever had a positive TB test? Yes No

Do you or your partner have Herpes? Yes No

Have you had any rashes or viruses since your last menstrual period? Yes No

Have you ever been diagnosed with any of the following sexually transmitted infections?

- | | | | | |
|------------------------------------|--------------------------------------|--------------------------------------|----------------------------------------|-----------------------------------|
| <input type="checkbox"/> Chlamydia | <input type="checkbox"/> Gonorrhea | <input type="checkbox"/> Herpes | <input type="checkbox"/> Genital Warts | <input type="checkbox"/> HPV |
| <input type="checkbox"/> HIV | <input type="checkbox"/> Hepatitis B | <input type="checkbox"/> Hepatitis C | <input type="checkbox"/> Trichomonas | <input type="checkbox"/> Syphilis |

Have you ever had Chicken Pox? Yes No Do you have cats in your home? Yes No

Have you ever had a blood transfusion? Yes No When? _____

Would you take a blood transfusion if it were an urgent medical necessity? Yes No

SUMMARY

Is there anything we need to know about you that has not been covered?

Do you have any special questions for your provider?
