Magnolia OB/GYN, LLC OF MYRTLE BEACH

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: __________________________

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? ☐ Yes ☐ No 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?

☐ Nausea ☐ Vomiting ☐ Breast Tenderness ☐ Urinary Frequency ☐ Pelvic Pressure ☐ Weight Gain
☐ 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

Please list any prescription or over the counter medications you have taken since your last menstrual period:

____

Medication Allergies: _______________________________________ Other: ____

Latex Allergy? □ Yes □ No Have you ever had any breast problems? □ Yes □ No

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:

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

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?

□ Chlamydia	□ Gonorrhea	□ Herpes	□ Genital Warts	□ HPV
□ HIV	□ Hepatitis B	□ Hepatitis C	□ Trichimonas	□ 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?

____
____
____
____

Are you considering adopting out? □ Yes □ No □ Need to Discuss