



## Initial Prenatal Visit Health History Questionnaire

Name \_\_\_\_\_ Date of Birth \_\_\_\_ / \_\_\_\_ / \_\_\_\_

Address \_\_\_\_\_

Phone Number: ( ) \_\_\_\_\_ - \_\_\_\_\_ Alternative Phone Number: ( ) \_\_\_\_\_ - \_\_\_\_\_

Marital Status  Single  Married  Divorced  Widowed  Life Partner

Primary Care Provider \_\_\_\_\_ Phone Number: ( ) \_\_\_\_\_ - \_\_\_\_\_

Local Pharmacy \_\_\_\_\_ Phone Number: ( ) \_\_\_\_\_ - \_\_\_\_\_

### Medications

Please list any medications that you take including over the counter medications, herbs, and supplements.

Name	Dose	Frequency

### Allergies

Please list any allergies to medications or foods

Name	Symptom/Reaction

### OB History

#### Menstrual History

1st day of last period: \_\_\_\_\_  Normal  Abnormal Monthly Periods:  Yes  No

Age of First Menstrual Cycle: \_\_\_\_\_

Menstrual Frequency: Every ( ) Days  Regular  Irregular Duration: ( ) Days

#### Family OB History

Patient Birth Weight: \_\_\_\_\_ lb. \_\_\_\_\_ oz. Previous Pregnancy Highest Birth Weight: \_\_\_\_\_ lb. \_\_\_\_\_ oz.

Father's Birth Weight: \_\_\_\_\_ lb. \_\_\_\_\_ oz.  History of Traumatic Births in close family members

#### Pregnancy History - Specify the Number of:

Total Pregnancies: \_\_\_\_\_ Full Term (37wks+) \_\_\_\_\_ Premature: \_\_\_\_\_ Abortions: \_\_\_\_\_

Miscarriages: \_\_\_\_\_ Ectopic: \_\_\_\_\_ Multiples: \_\_\_\_\_ Living Children: \_\_\_\_\_

Date of Delivery	Weeks Gestation	Hours in Labor	Birth Weight	Gender	Vaginal, C-Section, Vacuum, Forceps	Anesthesia (epidural, spinal, none)	Place of Delivery	Delivering Provider	Single or Multiple Birth	Pregnancy/ Delivery Complications

## Medical History

Check if you have had any of the following :

<input type="checkbox"/> Seasonal Allergies	<input type="checkbox"/> Hepatitis or Liver Disease
<input type="checkbox"/> Anemia/Blood Disorder	<input type="checkbox"/> Migraine or Neurologic Disorder
<input type="checkbox"/> Asthma/ Lung Disease	<input type="checkbox"/> Renal disease
<input type="checkbox"/> Autoimmune Disorder	<input type="checkbox"/> (Rh) Sensitized
<input type="checkbox"/> Abnormal Pap Smears	<input type="checkbox"/> Thyroid Disorder
<input type="checkbox"/> Blood Transfusion	<input type="checkbox"/> Trauma History (Car accident. Etc)
<input type="checkbox"/> Breast Disorder	<input type="checkbox"/> Uterine Abnormalities
<input type="checkbox"/> Depression	<input type="checkbox"/> Blood Clot in Leg or Lungs
<input type="checkbox"/> Psychiatric Disorder Specify: _____	<input type="checkbox"/> Anesthetic Complications
<input type="checkbox"/> Diabetes	<input type="checkbox"/> DES Exposure in Utero
<input type="checkbox"/> Heart Disease	<input type="checkbox"/> Confirmed COVID-19 Disease
<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> Cancer-please specify location:
<input type="checkbox"/> Infertility <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> HIV or AIDS
	<input type="checkbox"/> Other

### Substance

**Tobacco use:**  Never  Quit (when) \_\_\_\_\_  Current smoker: Packs/day, how many years \_\_\_\_\_

**Alcohol use:** Current  Yes  No If yes how many drinks/how often? \_\_\_\_\_

Pre-Pregnancy  Yes  No If yes, how many drinks/how often? \_\_\_\_\_

**Illicit Drug use** (including cocaine, steroids, etc)  Never  Past  Current  Marijuana by Prescription

Describe: \_\_\_\_\_

### Previous Surgeries/Procedures (including D&C and Procedures on the Cervix)

Surgery/Procedure	Year

### Genetic Screening

History of:	No	Yes - Who	History of:	No	Yes - Who
Neural Tube Defect (Spina Bifida, Anencephaly)			Autism Spectrum Disorder		
Trisomy 21 (Down Syndrome)			Mental Retardation		
Congenital Heart Disease/Defect			Muscular Dystrophy		
Cystic Fibrosis			Sickle Cell Disease or Trait (Forgetfulness)		
Tay-Sachs Disease			Other Inherited Genetic or Chromosomal Disorder		
Thalassemia (Alpha or Beta)			Type 1 Diabetes		
Canavan Syndrome			Recurrent Pregnancy Loss, or a Stillbirth		
Hemophilia or Blood Disease			Birth Defects (Cleft Palate, Gastroschisis,		
Huntington's Chorea			Other Genetic Disease or Trait		

### Infection History

Recent Exposure to HIV (Positive Partner)?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Have you Ever had a Genital Herpes Lesion?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Have you Ever been Exposed to Tuberculosis (TB)?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Have you had a Rash or Fever Since your Last Period?	<input type="checkbox"/> Yes <input type="checkbox"/> No
History of STD (Specify: Chlamydia, Syphilis, etc)	<input type="checkbox"/> Yes <input type="checkbox"/> No
Have you Ever had Chicken Pox or Been Vaccinated Against Chicken Pox?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Baby's Father - Any Other Medical Issues?	
Do you or Baby's Father have any of the following in your Ancestry? <input type="checkbox"/> African <input type="checkbox"/> Asian <input type="checkbox"/> Italian/Greek/Mediterranean <input type="checkbox"/> Latino	
Do you or Baby's Father have Ashkenazi Jewish Ancestry? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Are you and Baby's Father Closely Related (1st or 2nd Cousin)? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Have you Ever had Any Genetic Carrier Testing (Cystic Fibrosis, Sickle Cell, etc.)?:	
Do you Currently Feel Safe at Home?	
In the Past Year, Have you been Hit, Kicked, Punched, Intimidated, Raped, or Otherwise Injured at your Home or Elsewhere? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Will the Baby's Father be Involved in the Pregnancy or Care of the Baby?	

Patient/Guardian Signature: \_\_\_\_\_ Date \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_