FIRST PHYSICIANS GROUP
of Sarasota Memorial Health Care System

Initial Prenatal Visit Health History Questionnaire

Name _____ **Date of Birth** ____/____/____

Address _____

Phone Number: ( ) _____ - _____ **Alternative Phone Number:** ( ) _____ - _____

Martial 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 :

☐ Seasonal Allergies	☐ Hepatitis or Liver Disease
☐ Anemia/Blood Disorder	☐ Migraine or Neurologic Disorder
☐ Asthma/ Lung Disease	☐ Renal disease
☐ Autoimmune Disorder	☐ (Rh) Sensitized
☐ Abnormal Pap Smears	☐ Thyroid Disorder
☐ Blood Transfusion	☐ Trauma History (Car accident. Etc)
☐ Breast Disorder	☐ Uterine Abnormalities
☐ Depression	☐ Blood Clot in Leg or Lungs
☐ Psychiatric Disorder Specify:	☐ Anesthetic Complications
☐ Diabetes	☐ DES Exposure in Utero
☐ Heart Disease	☐ Confirmed COVID-19 Disease
☐ High Blood Pressure	☐ Cancer-please specify location:
☐ Infertility ☐ Yes ☐ No	☐ HIV or AIDS
	☐ 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 ☐ Nc 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)?	☐ Yes ☐ No
Have you Ever had a Genital Herpes Lesion?	☐ Yes ☐ No
Have you Ever been Exposed to Tuberculosis (TB)?	☐ Yes ☐ No
Have you had a Rash or Fever Since your Last Period?	☐ Yes ☐ No
History of STD (Specify: Chlamydia, Syphilis, etc)	☐ Yes ☐ No
Have you Ever had Chicken Pox or Been Vaccinated Against Chicken Pox?	☐ Yes ☐ No
Baby's Father - Any Other Medical Issues?	
Do you or Baby's Father have any of the following in your Ancestry? ☐ African ☐ Asian ☐ Italian/Greek/Mediterranean ☐ Latino	
Do you or Baby's Father have Ashkenazi Jewish Ancestry? ☐ Yes ☐ No	
Are you and Baby's Father Closely Related (1st or 2nd Cousin)? ☐ Yes ☐ 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 ar your Home or Elsewhere? ☐ Yes ☐ No	
Will the Baby's Father be Involved in the Pregnancy or Care of the Baby?	

Patient/Guardian Signature: _____ Date _____ / _____ / _____