WomanCare

Prenatal Questionnaire

Name_____ WomanCare Office_____

Occupation _____

Religion_____ Race_____ Marital Status_____ Years Married_____

Your answers will be kept confidential.

1. Father of Baby _____ Relationship_____
2. When was the first day of your last period? _____
3. Are you sure of the date? ☐ Yes ☐ No
4. Have you had any bleeding or spotting since your last period? ☐ Yes ☐ No
5. What is the conception date of this pregnancy? _____ ☐ Not Sure
6. Do you have any nutritional problems? _____
7. If you are on a special diet, what is it? _____
8. If you smoke, how much? _____ How many years?_____
9. If you drink alcohol, what type of drinks do you have? _____ How much in one week? _____
10. Have you or your sexual partner ever used street drugs? ☐ Yes ☐ No What kind? _____
11. Did either of you ever inject (shoot up) any drugs? ☐ Yes ☐ No What kind? _____
12. List any medical problems since you became pregnant: _____
    _____
    _____
    _____

13. **Medical and Family History**
    Family members are your grandparents, parents, sisters, brothers, sons and daughters.

	Yourself	Your Family	Who
A. Heart trouble/Rheumatic fever ……	☐ Yes ☐ No	☐ Yes ☐ No	_____
B. Mitral valve prolapse ……	☐ Yes ☐ No	☐ Yes ☐ No	_____
C. High blood pressure……..	☐ Yes ☐ No	☐ Yes ☐ No	_____
D. Thrombophlebitis……..	☐ Yes ☐ No	☐ Yes ☐ No	_____
E. Lung problems ……..	☐ Yes ☐ No	☐ Yes ☐ No	_____
F. Kidney disease……	☐ Yes ☐ No	☐ Yes ☐ No	_____
G. Cancer……	☐ Yes ☐ No	☐ Yes ☐ No	_____
H. Seizures (epilepsy)……	☐ Yes ☐ No	☐ Yes ☐ No	_____
I. Diabetes……	☐ Yes ☐ No	☐ Yes ☐ No	_____
J. Thyroid disease……	☐ Yes ☐ No	☐ Yes ☐ No	_____
K. Sexually transmitted diseases, such as gonorrhea, syphilis, herpes, genital warts, AIDS or HIV positive……	☐ Yes ☐ No	☐ Yes ☐ No	_____
L. Anemia……..	☐ Yes ☐ No	☐ Yes ☐ No	_____
M. Trouble with nerves/anxiety/depression……..	☐ Yes ☐ No	☐ Yes ☐ No	_____
N. Drinking problems……..	☐ Yes ☐ No	☐ Yes ☐ No	_____
O. Abnormalities of female organs……..	☐ Yes ☐ No	☐ Yes ☐ No	_____
P. Birth defects (like downs syndrome, muscular dystrophy, cystic fibrosis, hemophilia)……	☐ Yes ☐ No	☐ Yes ☐ No	_____
Q. Cerebral palsy/mental retardation……	☐ Yes ☐ No	☐ Yes ☐ No	_____
R. Neural tube defect (spina bifida; anencephaly)……	☐ Yes ☐ No	☐ Yes ☐ No	_____
S. Are you Filipino, Italian, Greek or Asian?.....	☐ Yes ☐ No	☐ Yes ☐ No	_____
T. Lived in Africa or Haiti?.....	☐ Yes ☐ No	☐ Yes ☐ No	_____
U. For black females – Have you had a sickle cell screen?.....	☐ Yes ☐ No	☐ Yes ☐ No	_____
V. Are you or the baby's father Jewish?.....	☐ Yes ☐ No	☐ Yes ☐ No	_____
W. Have any of your babies been infected at birth?.....	☐ Yes ☐ No	☐ Yes ☐ No	_____
X. Have you ever had professional counseling (psychiatric/ psychological)?.....	☐ Yes ☐ No	☐ Yes ☐ No	_____

14. If you have ever had surgery or have even been in the hospital, please complete the information below.

Operation or Hospitalization	Date	Doctor/Hospital

15. **Medications:** List any medications you usually take. Include prescription and over-the-counter drugs.

Name of Medicine	Dose	Date Started	For What Problem	Doctor	Taken During This Pregnancy
A.					
B.					
C.					

16. **Allergies:** If you are allergic to medicines, foods, plants, etc., fill in below.

What are you allergic to?	What kind of reaction did you have?
A.	
B.	
C.	
D.	
E.	
F.	

17. **In a life-threatening medical emergency, would you be willing to accept blood or blood products?** ☐ Yes ☐ No

18. **Pregnancy History:**

Number of Pregnancies_____ **Term**_____ **Pre-Term**_____ **Miscarriages/Pregnancy Terminations**_____ **Living Children**_____

19.

No.	Date	Name	Place of Delivery	Sex	Weeks Gestation	Weight	Type of Delivery	Anesthesia	Hours in Labor
1									
2									
3									
4									
5									
6									
7									

20. What problems did you have in a previous pregnancy or pregnancies?