Premier Perinatal

You are being asked to complete this questionnaire to provide out office with a complete history on you and your family to help the staff identify your risk factors associated with this pregnancy.

Date: _____

Name: _____

Age:_____Date of birth: _____Ethnicity:_____

Occupation:_____ ☐ Full time ☐ Part time

Last grade completed:_____

Present Weight:_____Present Height: _____

History of Contraception:_____

Last Menstrual Period (1st day): _____

At what age did you have your first period: _____

How many days do your periods: _____

Number of days between periods: _____

Date of last Pap smear: _____

Past Pregnancies: Please list any and all pregnancies below. Please include whether a D&C was needed for any miscarriages/terminations/births.

Date	Miscarriage	Termination	Delivery Method (Vaginal / Cesarean Section)	Male/ Female	Birth Weight
1st : / /					
2nd: / /					
3rd: / /					
4th: / /					
5th: / /					

Please describe any complications associated with the pregnancies listed above:

_____

_____

_____

☐ Patient has language barrier, unable to complete form. Language: _____

Reviewed by: _____ Date: _____

Previous Infants: (check if any apply to the past pregnancies)

	1st	2nd	3rd	4th	5th
Premature	☐	☐	☐	☐	☐
Under 5 ½ lbs.	☐	☐	☐	☐	☐
Over 9 lbs.	☐	☐	☐	☐	☐
Death	☐	☐	☐	☐	☐
Birth Defect	☐	☐	☐	☐	☐
Genetic	☐	☐	☐	☐	☐
Chromosomal Disorder	☐	☐	☐	☐	☐
Cerebral Palsy	☐	☐	☐	☐	☐
Mental Retardation	☐	☐	☐	☐	☐
Intensive Care	☐	☐	☐	☐	☐

Pregnancy Complications: Past or present:

☐ Elevated Blood Pressure ☐ Diabetes

☐ Hemorrhage ☐ Premature Labor

Is/was oral terbutaline or a terbutaline pump needed? ☐ Yes ☐ No

Indicate which of the following, if any, you may be experiencing:

Weight loss/gain in past year	☐	Shortness of Breath	☐
Skip meals / Fasting	☐	Fatigue	☐
Mood Disorders	☐	Enlargement of the neck	☐
Binges	☐	Cough	☐
Anorexia	☐	Stomach problems, pain, indigestion	☐
Bulimia	☐	Abdominal cramping or pain	☐
Loss of appetite	☐	Pre-pregnancy irregular menstruation	☐
Food allergies/intolerances	☐	Sore muscles/joints, arm/leg weakness	☐
PKU intolerance	☐	Arthritis	☐
Diarrhea	☐	Numbness or tingling	☐
Constipation	☐	Loss of strength	☐
Headache	☐	Rash	☐
Visual disturbance	☐	Hair loss	☐
Sore throat	☐	Difficulty hearing	☐
Chest pain / Palpitations	☐	Hoarseness	☐

Please list any allergies to medications: _____

_____

Please list names of any of the following medications/vitamins you are currently taking:

Vitamin/Mineral supplements: _____

Other supplements: _____

Prescription drugs: _____

Over-the-counter drugs: _____

Do you have an infertility history: Yes ☐ No ☐

Duration: _____

Treatment: _____

Medication prescribed: _____

History of abnormally-shaped uterus: Yes ☐ No ☐

History of uterine surgery: Yes ☐ _____ No ☐

Current exposure: (check if yes)

Tobacco	☐	Number of cigarettes per day: _____.
Other people's smoke	☐	
Alcohol	☐	Number per day: _____.
Wine, Beer, Liquor	☐	Kind of alcohol: _____.
Marijuana	☐	
Cocaine	☐	
IV drugs	☐	
Multiple partners	☐	
Cats	☐	
Organic solvents	☐	(wood preservatives, sealants, paint varnish, polyurethane)
Heavy metals	☐	
Raw meats/fish	☐	
Paint stripper	☐	
Radiation	☐	(Xrays, nuclear industry, company that sterilizes/preserves)
Pesticide	☐	(insect killers)
Oven cleaners	☐	
Ceramic	☐	

Please list any hobbies: _____

_____

Work:

How many hours do you work each day? _____

How many hours do you stand at work each day? _____

How long does it take you to get to work one way? _____

How do you get to work? _____

Do you climb a flight of stairs?	No	☐	Moderate	☐	Often	☐
How tired are you at work?	Mild	☐	Moderate	☐	Severe	☐
Do you have a chance to rest at work?	No	☐	Sometimes	☐	Often	☐
Do you operate heavy equipment?	No	☐	Yes	☐		
Stress at work?	Mild	☐	Moderate	☐	Severe	☐
Are you generally happy at work?	No	☐	Sometimes	☐	Always	☐

Household:

Number of people living in house? _____

Number of preschool children? _____

Do you have help at home? Yes ☐ No ☐

Type of heavy housework you do: _____

Do you feel stress at home? Yes ☐ No ☐

What do you do to handle this stress? _____

Exercise:

Recreational exercise	*Hours per week*	*How tired at end of exercise:*
Type: _____	1-2 ☐ 2-4☐ +4☐	mild ☐ moderate ☐ extreme ☐
_____	1-2 ☐ 2-4☐ +4☐	mild ☐ moderate ☐ extreme ☐
_____	1-2 ☐ 2-4☐ +4☐	mild ☐ moderate ☐ extreme ☐

Surgery:

Procedure	Hospital
Date:	
Date:	
Date:	
Date:	

Medical History: (check any that apply)

	Patient	Current Partner	Family (either side)
High blood pressure			
Heart disease			
Lung disease			
Asthma			
Diabetes			
Thyroid disease			
Kidney disease			
Infections			
Herpes			
Kidney/Bladder			
Hepatitis			
Group B Strep			
Syphilis			
Gonorrhea			
Chlamydia			
Cytomegalovirus			
Lupus			
ITP			
Hemophilia (bleeding disorder)			
Seizures (convulsions)			
Mental retardation			
Psychiatric illness			
Hereditary disorders			
Congenital abnormalities			
Tay Sachs			
Spina bifida			
Hydrocephalus			
Cystic fibrosis			
DES exposure			
S.I.D.S			
Multiple pregnancies			
Prematurity			
Stillbirth			
Infant death			
Abnormal Pap smear			
History of blood clot/embolus			
Any other conditions:			

Cancer (Type): _____

Prenatal Genetic Screen:

1. Will you be 35 years or older when the baby is due? Yes ☐ No ☐

2. Have you, the baby's father, or anyone in either of your families ever had any of the following disorders? Yes ☐ No ☐

	You	Baby's Father	Family
Down Syndrome			
Other chromosomal abnormalities			
Neural tube defect (spina bifida, anencephaly)			
Hemophilia			
Muscular dystrophy			
Cystic fibrosis			
Other genetic defects			

3. Do you have a birth defect? Yes ☐ No ☐
If yes, what is it? _____

4. Does the baby's father have a birth defect? Yes ☐ No ☐
If yes, what is it? _____

5. In any previous pregnancies, have you had a child born dead or alive, with a birth defect not listed in question 2 above? Yes ☐ No ☐
If yes, what was the defect? _____

6. In any previous pregnancies, did the baby's father have a child born dead or alive, with a birth defect not listed in question 2 above? Yes ☐ No ☐
If yes, what was the defect? _____

7. Do you or the baby's father have any close relatives with mental retardation? Yes ☐ No ☐
If yes, indicate relationship of affected person to you or the baby's father and the cause if known:
_____

8. Do you or the baby's father have any close relatives with a birth defect, any familiar disorder or a chromosomal abnormality not listed above? Yes ☐ No ☐
If yes, indicate the condition and relationship of affected person to you or the baby's father:
_____

9. In any previous pregnancies have you or the baby's father had a stillborn child, or three or more first-trimester spontaneous pregnancy losses? Yes ☐ No ☐

10. Have either of you had a chromosomal study? Yes ☐ No ☐
If yes, indicate the results: _____

11. Are you or the baby's father of Jewish ancestry? Yes ☐ No ☐

If yes, have either of you been screened for Tay-Sachs disease? Yes ☐ No ☐

Results: _____

12. Are you or the baby's father black? Yes ☐ No ☐

If yes, have either of you been screened for sickle cell trait? Yes ☐ No ☐

Results: _____

13. Are you or the baby's father of Italian, Greek or Mediterranean descent? Yes ☐ No ☐

If yes, have either of you been screened for B-thalassemia? Yes ☐ No ☐

Results: _____

14. Are you or the baby's father of Philippine or Southeast Asian ancestry? Yes ☐ No ☐

If yes, have either of you been screened for A-thalassemia? Yes ☐ No ☐

Results: _____

15. Excluding iron and vitamins, have you taken any medications or recreational drugs since being pregnant or since your last menstrual period? Yes ☐ No ☐

Including non-prescription drugs? Yes ☐ No ☐

If yes, give names of medication and time(s) taken during pregnancy:

_____

16. Have you ever been emotionally or physically abused by your partner or someone important to you? Yes ☐ No ☐

17. Within the last year, have you been hit, slapped, kicked or otherwise physically hurt by someone? Yes ☐ No ☐

18. Since your pregnancy began, have you been hit, slapped, kicked or otherwise physically hurt by someone? Yes ☐ No ☐

19. Within the last year has anyone forced you to have sexual activities? Yes ☐ No ☐

20. Are you afraid of your partner or someone else? Yes ☐ No ☐