CURRENT PREGNANCY

PATIENT		FATHER OF BABY	
NAME	DOB	NAME	DOB
ADDRESS		ADDRESS	
HOME PHONE	WORK PHONE	HOME PHONE	WORK PHONE
EDUCATION (HIGHEST GRADE COMPLETED – IN WHAT?)		EDUCATION (HIGHEST GRADE COMPLETED – IN WHAT?)	
OCCUPATION	EMPLOYER	OCCUPATION	EMPLOYER
LANGUAGE	RELIGION	LANGUAGE	RELIGION

1. WHAT WAS YOUR WEIGHT BEFORE PREGNANCY? _____ #
2. WHAT WAS THE FIRST DAY OF YOUR LAST NORMAL MENSTRUAL PERIOD? _____
3. WAS THIS PERIOD ☐ LONGER or ☐ SHORTER THAN USUAL, or ☐ NORMAL?

	YES	NO
4. WAS THIS PREGNANCY UNPLANNED?		
5. HAVE YOU EVER TRIED BUT COULDN'T GET PREGNANT FOR OVER ONE YEAR?		
6. ARE YOU OR THE BABY'S FATHER UNHAPPY ABOUT THIS PREGNANCY?		
7. IS YOUR RELATIONSHIP WITH THE BABY'S FATHER STABLE AND FULFILLING?		
8. SINCE YOUR LAST MENSTRUAL PERIOD HAVE YOU USED THE FOLLOWING DRUGS:		
- ACCUTANE		
- STREPTOMYCIN OR GENTAMICIN		
- ANTI-CANCER MEDICINES		
- BIRTH CONTROL PILLS		
- COUMADIN (BLOOD THINNER)		
- DILANTIN, DEPAKENE OR OTHER DRUGS FOR EPILEPSY		
- FLAGYL OR METRONIDAZOLE		
- OTHER VITAMINS (MORE THAN MINIMUM DAILY REQUIREMENTS)		
9. HAVE YOU OR THE BABY'S FATHER TAKEN STREET DRUGS SUCH AS COCAINE, MARIJUANA, AMPHETAMINES, LSD, HEROIN OR QUAALUDES?		
10. HAVE YOU BEEN EXPOSED TO POTENTIALLY DANGEROUS CHEMICALS SUCH AS AGENT ORANGE, DIOXIN, INSECTICIDES?		

11. LIST ANY MEDICATIONS OR DRUGS YOU HAVE TAKEN SINCE YOUR LAST MENSTRUAL PERIOD:

_____

_____

	DATE	YES	NO
12. HAVE YOU HAD BLEEDING OR SPOTTING SINCE YOUR LAST MENSTRUAL PERIOD?			
13. HAVE YOU HAD ANY OF THESE SYMPTOMS SINCE YOUR LAST MENSTRUAL PERIOD?			
- CRAMPS OR ABDOMINAL PAIN			
- ENLARGED OR PAINFUL BREASTS			
- MORE FREQUENT URINATION			
- FATIGUE			
- NAUSEA AND VOMITING			
- POSITIVE PREGNANCY TEST (please write date of first positive result)			
- ANY PROBLEMS WITH HEADACHES, DIZZINESS, BLACKING OUT, NUMBNESS OR PARALYSIS?			
- DO YOU HAVE ANY OF THE FOLLOWING: ☐ LOSS OF APPETITE ☐ PROBLEMS GETTING TO SLEEP OR STAYING ASLEEP ☐ FEELING ANXIOUS OR DEPRESSED ☐ CRYING WITHOUT REASON ☐ THOUGHTS OF SUICIDE			

- HAVE YOU EVER HAD PROFESSIONAL COUNSELING (PSYCHIATRIC / PSYCHOLOGICAL)?		
- ARE PROBLEMS AT HOME OR WORK BOTHERING YOU?		

PREGNANCY RISK FACTORS

	YES	NO
1. WILL YOU BE 35 OR OLDER WHEN THE BABY IS BORN?		
2. DO ANY FAMILY MEMBERS HAVE THESE CONDITIONS THAT CAN POSSIBLY BE INHERITED?		
- CYSTIC FIBROSIS		
- DOWN SYNDROME		
- MUSCULAR DYSTROPHY		
- HEART ATTACK OR STROKE BEFORE AGE 45		
- HEMOPHILIA		
- HUNTINGTON'S DISEASE		
- HYDROCEPHALUS		
- NEURAL TUBE DEFECT (SPINA BIFIDA)		
- PKU (PHENYLKETONURIA)		
- SICKLE CELL ANEMIA		
- SPINAL MUSCULAR ATROPHY (SMA)		
- TAY SACHS DISEASE (ASHKENAZI JEWS)		
- THALASSEMIA (ANEMIA) (MEDITERRANEAN AREA)		
- RECURRING MISCARRIAGES		
- OTHER: _____		
3. ARE YOU AND THE BABY'S FATHER RELATED TO EACH OTHER (COUSINS OR OTHERWISE)?		
4. HAVE YOU BEEN EXPOSED TO X-RAYS SINCE YOUR LAST MENSTRUAL PERIOD?		
5. SINCE YOUR LAST MENSTRUAL PERIOD, HAVE YOU BEEN EXPOSED TO GERMAN MEASLES (RUBELLA) OR CHICKEN POX?		
6. WITHIN THE LAST YEAR, HAVE YOU BEEN HIT, SLAPPED, KICKED OR IN SOME WAY PHYSICALLY HURT BY SOMEONE?		
7. SINCE YOU HAVE BEEN PREGNANT, HAVE YOU BEEN HIT, SLAPPED, KICKED OR IN SOME WAY PHYSICALLY HURT BY SOMEONE?		
8. IN THIS LAST YEAR, HAS ANYONE FORCED YOU TO HAVE SEXUAL ACTIVITIES?		
9. DO YOU EAT RAW MEAT OR CHANGE A CAT LITTER BOX?		
10. DO YOU SUSPECT THAT YOU MAY HAVE BEEN EXPOSED TO THE AIDS VIRUS THROUGH SEXUAL CONTACT, DIRTY NEEDLES OR BLOOD TRANSFUSIONS?		
11. DO YOU WORK IN AN INSTITUTION WITH MENTALLY OR PHYSICALLY HANDICAPPED?		
12. DO YOU HAVE CHILDREN IN PRESCHOOL?		
13. HAVE YOU HAD ILLNESS WITH FEVERS SINCE YOUR LAST MENSTRUAL PERIOD?		
14. HAVE YOU USED SAUNAS OR HOT TUBS SINCE YOUR LAST MENSTRUAL PERIOD?		

BABY'S FATHER - FAMILY HISTORY

	BABY'S FATHER		BABY'S FATHER'S FAMILY	
	YES	NO	YES	NO
1. BIRTH DEFECTS				
2. CANCER				
3. HEART PROBLEMS, HIGH BLOOD PRESSURE, STROKES				
4. DIABETES, THYROID PROBLEMS				
5. ANEMIA OR FAILURE OF BLOOD TO CLOT				
6. INHERITABLE CLOTTING DISORDER (FACTOR V LEIDEN, VON WILLEBRAND'S, ETC)				
7. TWINS OR OTHER MULTIPLE BIRTHS				
8. EMOTIONAL PROBLEMS OR PROBLEMS WITH ALCOHOL OR DRUGS				
9. INHERITED DISEASES: _____				

ADDITIONAL COMMENTS: _____

_____

_____ PATIENT SIGNATURE: _____