

Name \_\_\_\_\_ Age \_\_\_\_\_ Date \_\_\_\_\_

## Bellegrove OB-GYN Prenatal Questionnaire

*Welcome to Bellegrove OB-GYN. We look forward to providing your pregnancy care. In order to help us provide the best care for you, we need to learn more about your medical and social history. Please complete the following information. Feel free to ask us for clarification if you do not understand the nature of any of the questions.*

Ethnicity \_\_\_\_\_ Planned Pregnancy **No Yes** Partner supportive **No Yes**

Father of Baby's Name (FOB) \_\_\_\_\_ FOB Birth Date \_\_\_\_\_

FOB Occupation \_\_\_\_\_ FOB Ethnicity \_\_\_\_\_

**Pregnancies**

Total number of pregnancies \_\_\_\_\_  
 Number of full term preg. \_\_\_\_\_  
 Number of premature preg. \_\_\_\_\_  
 Number of terminations \_\_\_\_\_  
 Number of miscarriages \_\_\_\_\_  
 Number of ectopic preg. \_\_\_\_\_  
 Number of multiples \_\_\_\_\_  
 Number of living children \_\_\_\_\_

**Menses**

1<sup>st</sup> day of last period (LMP)? \_\_\_\_\_  
 Are your periods regular? \_\_\_\_\_  
 How frequent are your periods? \_\_\_\_\_  
 Age at first period? \_\_\_\_\_  
 Was your last period normal? \_\_\_\_\_  
 Taking BCP at conception? \_\_\_\_\_  
 Date of 1<sup>st</sup> positive preg. test? \_\_\_\_\_  
 Type of test (circle one) **Blood Urine**

Pregnancy Number	1	2
Date of delivery/Miscarriage		
# Weeks of pregnancy		
Hours of labor		
Weight of baby		
Sex of baby (circle one)	Male    Female	Male    Female
Type of delivery (circle one)	C-Section    Vaginal    Forceps    Vacuum	C-Section    Vaginal    Forceps    Vacuum
Anesthesia (circle one)	Epidural    Spinal    General    None	Epidural    Spinal    General    None
Hospital / Location		
Obstetrician		
Complications		
Name of baby		

Pregnancy Number	3	4
Date of delivery/Miscarriage		
# Weeks of pregnancy		
Hours of labor		
Weight of baby		
Sex of baby (circle one)	Male    Female	Male    Female
Type of delivery (circle one)	C-Section    Vaginal    Forceps    Vacuum	C-Section    Vaginal    Forceps    Vacuum
Anesthesia (circle one)	Epidural    Spinal    General    None	Epidural    Spinal    General    None
Hospital / Location		
Obstetrician		
Complications		
Name of baby		

<b>Pregnancy Number</b>	<b>5</b>				<b>6</b>			
Date of delivery/Miscarriage								
# Weeks of pregnancy								
Hours of labor								
Weight of baby								
Sex of baby (circle one)	Male		Female		Male		Female	
Type of delivery (circle one)	C-Section	Vaginal	Forceps	Vacuum	C-Section	Vaginal	Forceps	Vacuum
Anesthesia (circle one)	Epidural	Spinal	General	None	Epidural	Spinal	General	None
Hospital / Location								
Obstetrician								
Complications								
Name of baby								

<b>Pregnancy Number</b>	<b>7</b>				<b>8</b>			
Date of delivery/Miscarriage								
# Weeks of pregnancy								
Hours of labor								
Weight of baby								
Sex of baby (circle one)	Male		Female		Male		Female	
Type of delivery (circle one)	C-Section	Vaginal	Forceps	Vacuum	C-Section	Vaginal	Forceps	Vacuum
Anesthesia (circle one)	Epidural	Spinal	General	None	Epidural	Spinal	General	None
Hospital / Location								
Obstetrician								
Complications								
Name of baby								

<b>Pregnancy Number</b>	<b>9</b>				<b>10</b>			
Date of delivery/Miscarriage								
# Weeks of pregnancy								
Hours of labor								
Weight of baby								
Sex of baby (circle one)	Male		Female		Male		Female	
Type of delivery (circle one)	C-Section	Vaginal	Forceps	Vacuum	C-Section	Vaginal	Forceps	Vacuum
Anesthesia (circle one)	Epidural	Spinal	General	None	Epidural	Spinal	General	None
Hospital / Location								
Obstetrician								
Complications								
Name of baby								

**Medications You Take** (please include name, dosage and frequency of medication)  None

1. \_\_\_\_\_ 4. \_\_\_\_\_  
2. \_\_\_\_\_ 5. \_\_\_\_\_  
3. \_\_\_\_\_ 6. \_\_\_\_\_

**Allergies** (please include allergy and reaction)  No known allergies

1. \_\_\_\_\_ 4. \_\_\_\_\_  
2. \_\_\_\_\_ 5. \_\_\_\_\_  
3. \_\_\_\_\_ 6. \_\_\_\_\_

**Medical History** (please check no or yes; if yes, please explain)

Heart disease	<input type="checkbox"/> No <input type="checkbox"/> Yes	_____
High blood pressure	<input type="checkbox"/> No <input type="checkbox"/> Yes	_____
Respiratory problems	<input type="checkbox"/> No <input type="checkbox"/> Yes	_____
Neurologic problems	<input type="checkbox"/> No <input type="checkbox"/> Yes	_____
Diabetes	<input type="checkbox"/> No <input type="checkbox"/> Yes	_____
Autoimmune disorder	<input type="checkbox"/> No <input type="checkbox"/> Yes	_____
Kidney disease/UTI	<input type="checkbox"/> No <input type="checkbox"/> Yes	_____
Depression/Anxiety	<input type="checkbox"/> No <input type="checkbox"/> Yes	_____
Hepatitis	<input type="checkbox"/> No <input type="checkbox"/> Yes	_____
Pulmonary embolism	<input type="checkbox"/> No <input type="checkbox"/> Yes	_____
Blood clots in legs	<input type="checkbox"/> No <input type="checkbox"/> Yes	_____
Thyroid problems	<input type="checkbox"/> No <input type="checkbox"/> Yes	_____
Blood transfusion	<input type="checkbox"/> No <input type="checkbox"/> Yes	_____
RH sensitized	<input type="checkbox"/> No <input type="checkbox"/> Yes	_____
Drug/Latex allergy	<input type="checkbox"/> No <input type="checkbox"/> Yes	_____
Breast problems	<input type="checkbox"/> No <input type="checkbox"/> Yes	_____
Operations	<input type="checkbox"/> No <input type="checkbox"/> Yes	_____
Hospitalizations	<input type="checkbox"/> No <input type="checkbox"/> Yes	_____
Anesthetic problems	<input type="checkbox"/> No <input type="checkbox"/> Yes	_____
Uterine abnormalities	<input type="checkbox"/> No <input type="checkbox"/> Yes	_____
Other	<input type="checkbox"/> No <input type="checkbox"/> Yes	_____

**Family History** (please check no or yes; if yes, who and note if a personal history or of baby's father)

Cardiac defects	<input type="checkbox"/> No <input type="checkbox"/> Yes	_____
Birth defects	<input type="checkbox"/> No <input type="checkbox"/> Yes	_____
Familial disorders	<input type="checkbox"/> No <input type="checkbox"/> Yes	_____
Diabetes	<input type="checkbox"/> No <input type="checkbox"/> Yes	_____
Hypertension	<input type="checkbox"/> No <input type="checkbox"/> Yes	_____

**Social History** (please check no or yes; if yes, please explain)

Tobacco use	<input type="checkbox"/> No <input type="checkbox"/> Yes	_____
Alcohol use	<input type="checkbox"/> No <input type="checkbox"/> Yes	_____
Recreational drug use	<input type="checkbox"/> No <input type="checkbox"/> Yes	_____
Domestic violence	<input type="checkbox"/> No <input type="checkbox"/> Yes	_____
Your Occupation		_____

**Genetics Screening / Teratology Counseling** (please check no or yes; if yes, please explain)

Do you or your partner have a personal or family history of any of the following?

Down syndrome	<input type="checkbox"/> No <input type="checkbox"/> Yes	_____
Cystic Fibrosis	<input type="checkbox"/> No <input type="checkbox"/> Yes	_____
Thalassemia (if yes please circle one)	<input type="checkbox"/> No <input type="checkbox"/> Yes	_____
		<b>Italian Greek Mediterranean Asian Other</b>
Neural Tube Defect	<input type="checkbox"/> No <input type="checkbox"/> Yes	_____
Congenital Heart Defect	<input type="checkbox"/> No <input type="checkbox"/> Yes	_____
Ashkenazi Jewish Ancestry	<input type="checkbox"/> No <input type="checkbox"/> Yes	_____
Tay-Sachs	<input type="checkbox"/> No <input type="checkbox"/> Yes	_____
Canavan Disease	<input type="checkbox"/> No <input type="checkbox"/> Yes	_____
Sickle cell disease or trait	<input type="checkbox"/> No <input type="checkbox"/> Yes	_____
Hemophilia or other blood disorders	<input type="checkbox"/> No <input type="checkbox"/> Yes	_____
Muscular Dystrophy	<input type="checkbox"/> No <input type="checkbox"/> Yes	_____
Mental Retardation/Autism	<input type="checkbox"/> No <input type="checkbox"/> Yes	_____
If yes, was person tested for Frag X	<input type="checkbox"/> No <input type="checkbox"/> Yes	_____
Other inherited genetic disorders	<input type="checkbox"/> No <input type="checkbox"/> Yes	_____
Patient or baby's father had a child with birth defects not listed?	<input type="checkbox"/> No <input type="checkbox"/> Yes	_____
Recurrent pregnancy loss/stillborn	<input type="checkbox"/> No <input type="checkbox"/> Yes	_____
Medications/Illicit/Recreational drugs/alcohol since LMP	<input type="checkbox"/> No <input type="checkbox"/> Yes	_____
If yes, Agent(s) and strength/dosage		_____
Any other genetic concerns?	<input type="checkbox"/> No <input type="checkbox"/> Yes	_____

**Infection History** (please check no or yes; if yes, please explain)

Lives with someone with TB or exposed to TB	<input type="checkbox"/> No <input type="checkbox"/> Yes	_____
Patient or partner with genital herpes	<input type="checkbox"/> No <input type="checkbox"/> Yes	_____
Rash or viral illness since last menstrual period	<input type="checkbox"/> No <input type="checkbox"/> Yes	_____
History of STD, GC, Chlamydia, HPV, Syphilis	<input type="checkbox"/> No <input type="checkbox"/> Yes	_____
At risk for chicken pox (as no history or vaccine)	<input type="checkbox"/> No <input type="checkbox"/> Yes	_____
Other _____		_____

**Additional History or Comments**

*Please feel free to tell us about any other health concerns not mentioned above.*