

# Haugen OB/GYN Prenatal Questionnaire

(place patient label here)

Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_

Marital Status: \_\_\_\_\_ Name of Partner: \_\_\_\_\_ Physician: \_\_\_\_\_

Occupation: \_\_\_\_\_ Hospital (please circle): Abbott Mother Baby -or- Fairview Southdale

First day of last menstrual period: \_\_\_\_\_ How often do you get a period? \_\_\_\_\_  
How many days do they last? \_\_\_\_\_ Flow: \_\_\_\_\_ Heavy \_\_\_\_\_ Moderate \_\_\_\_\_ Light  
When did you have a positive pregnancy test? \_\_\_\_\_ Was it a blood or urine test? \_\_\_\_\_

## Pregnancy Symptoms:

\_\_\_\_ Nausea \_\_\_\_ Vomiting \_\_\_\_ Loss of appetite \_\_\_\_ Cramping \_\_\_\_ Pelvic Pain \_\_\_\_ Abdominal Pain  
\_\_\_\_ Breast tenderness \_\_\_\_ Vaginal bleeding \_\_\_\_ Fatigue \_\_\_\_ Lightheaded \_\_\_\_ Headache \_\_\_\_ Heartburn  
\_\_\_\_ Hemorrhoids \_\_\_\_ Back pain \_\_\_\_ Pica (craving or eating a nonfood substance) \_\_\_\_ Vaginal discharge  
\_\_\_\_ Constipation \_\_\_\_ Diarrhea \_\_\_\_ Urinary urgency \_\_\_\_ Change of urine color \_\_\_\_ Urinary frequency

## Pregnancy History:

Date	Weeks at delivery	Hours of Labor	M/F	Type of Delivery	Complications	Where delivered
1)						
2)						
3)						
4)						
*If more than 4 pregnancies please add on the back of this form at the bottom of the page						

History of miscarriage or abortion? \_\_\_\_\_

Have you had an ultrasound yet this pregnancy? Y / N

If yes, when, where and why: \_\_\_\_\_

Have you gained or lost weight so far this pregnancy? \_\_\_\_\_

How much? \_\_\_\_\_ Over what period of time? \_\_\_\_\_

History of any significant illnesses/diseases/hospitalizations? \_\_\_\_\_

History of any surgical procedures? \_\_\_\_\_

Family history of any significant illnesses/diseases? \_\_\_\_\_

When was you last pap smear? \_\_\_\_\_ What were the results? \_\_\_\_\_

Have you used any alcohol, tobacco or illicit drugs so far this pregnancy? \_\_\_\_\_

Are you safe at home &/or work? \_\_\_\_\_ Do you have a history of domestic violence? \_\_\_\_\_

What medications (including supplements) have you taken so far this pregnancy? \_\_\_\_\_

Do you have any other medications you haven't taken yet this pregnancy? \_\_\_\_\_

Date of last flu shot? \_\_\_\_\_ Do you have close contact with children on a regular basis? Y / N

Do you have any drug allergies? Y / N If Yes, to what? \_\_\_\_\_

What was the reaction? \_\_\_\_\_

Are you on any special diet or dietary restrictions? \_\_\_\_\_

Do you have any cats in the home? Y / N If Yes, are they \_\_\_ Indoor \_\_\_ Outdoor \_\_\_ Both

Do you have any exposure risks at work or home?

\_\_\_ **No obvious risky exposure**

\_\_\_ Stay at home mom/caring for own children

\_\_\_ Chemical/radiation exposure

\_\_\_ Exposure to lead

\_\_\_ Extensive travel

\_\_\_ Heavy lifting

\_\_\_ High level of stress

\_\_\_ Work in health care clinic

\_\_\_ Work in hospital

\_\_\_ Work with children (school or daycare)

\_\_\_ Sit for prolonged periods

\_\_\_ Stand for prolonged periods

#### Infection/Exposure History:

\_\_\_ No history of infectious diseases

\_\_\_ History of STD, GC, Chlamydia, HPV, Syphilis

\_\_\_ Sexual partner who has had genital herpes

\_\_\_ Vaccinated or is at risk for Hepatitis B

\_\_\_ Rash or viral illness since last menstrual period

\_\_\_ Is at risk for HIV due to IV drug use or partner with HIV

\_\_\_ Has had a history of genital herpes

\_\_\_ History of chicken pox or Immunization

\_\_\_ Lives or has lived with someone with TB

#### Genetic screening:

Will you be age 35 or older at the time of delivery? \_\_\_\_\_

Are you of Greek, Mediterranean or Asian background? \_\_\_\_\_

Is there family history of:

\_\_\_ Open Neural Tube Defect (Spina Bifida, Anencephaly, Meningomyelocele)

\_\_\_ Congenital Heart Defect

\_\_\_ Down's Syndrome

\_\_\_ Jewish or French Canadian Ancestry

\_\_\_ Canavan Disease

\_\_\_ Sickle Cell Disease or trait

\_\_\_ Hemophilia or other blood disorders

\_\_\_ Muscular Dystrophy

\_\_\_ Cystic Fibrosis

\_\_\_ Huntington's Chorea

\_\_\_ Mental Retardation or Autism If so, were they tested for Fragile X? \_\_\_\_\_

\_\_\_ Other inherited genetic or chromosomal disorders

\_\_\_ Maternal metabolic disorder (ie. Diabetes or PKU)

Does the father of the baby have any children with birth defects not listed above? \_\_\_\_\_

If additional pregnancies to list:

Date	Weeks at delivery	Hours of Labor	M/F	Type of Delivery	Complications	Where delivered
5)						
6)						
7)						
8)						
9)						
10)						