

# 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)						