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)						