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Name

Health Record Number

Today's Date

# Prenatal Questionnaire

Our goal is for you and your baby to be as healthy as possible. Please complete this questionnaire before your first prenatal visit and bring it with you to your appointment. Your health care team will review the questionnaire with you and use it for your care.

## General Information

### Patient Information

Preferred name: _____

Preferred pronoun (e.g. she, he, they, or xe): _____

Address (street, city, state, zip): _____

Phone: Mobile: _____ Home: _____ Work: _____

Date of birth: _____

Marital status: ☐ Married ☐ Single ☐ Widowed ☐ Divorced ☐ Separated ☐ Domestic Partner
☐ Other: _____

Ethnic group/race: _____

Occupation: _____

Years of education: _____

Religion: _____

Who to contact in case of emergency: _____

Relationship: _____

Phone: Mobile: _____ Home: _____ Work: _____

Additional contact: _____

Relationship: _____

Phone: Mobile: _____ Home: _____ Work: _____

Are you either a surrogate or gestational carrier for this pregnancy? ☐ Yes ☐ No

### Partner Information

Name of partner: _____

Preferred pronoun (e.g. she, he, they, or xe): _____

Is this the biological father of baby? ☐ Yes ☐ No ☐ Unknown

Age: _____

Ethnic group/race: _____

Religion: _____

Occupation: _____

## Your Body Before This Pregnancy

Was this a planned pregnancy? ☐ Yes ☐ No

First day of your last period: _____ ☐ Exact (+/- one day) ☐ Approximate ☐ Unknown

- Was your period normal in number of days and flow? ☐ Normal ☐ Abnormal
- Were your periods every 24–32 days? ☐ Yes ☐ No: _____

Date of conception, if known: _____

Did you have fertility treatment for this pregnancy? ☐ Yes ☐ No

- If yes, please explain: _____

  ☐ IUI (date): _____

  ☐ Embryo Transfer (date): _____

Method of birth control in the last year:

☐ None ☐ Pills ☐ Condoms ☐ IUD ☐ Nexplanon ☐ Ring ☐ Patch ☐ Depo-Provera injections

☐ Natural family planning ☐ Other: _____

When did you stop using this method? _____

Did you have 3 normal natural menstrual cycles in a row prior to conceiving? ☐ Yes ☐ No

Were you breastfeeding during your last 3 menstrual cycles? ☐ Yes ☐ No

- If yes, are you breastfeeding now? ☐ Yes ☐ No
  - If no, date stopped: _____

Are you planning to breastfeed with this pregnancy? ☐ Yes ☐ No ☐ Undecided

Have you had problems breastfeeding in the past? ☐ Yes ☐ No

- If yes, please explain: _____

Weight before becoming pregnant: _____

## Current Symptoms

List any concerns or problems that you have with your current pregnancy *(e.g. nausea and vomiting, vaginal bleeding, abdominal pain, or other symptoms):*

## Allergies and Medications

Allergies: Which drugs or medicines are you allergic or sensitive to?

| Medication | Reaction |
|---|---|
| | |
| | |
| | |
| | |

Please list any medications you are currently taking *(include prescription, over the counter, vitamins, herbs)*:

| Medication | Dosage |
|---|---|
| | |
| | |
| | |
| | |

## Past Obstetric and Gynecologic History

Previous Pregnancies *(list all pregnancies, include miscarriages or abortions):*

| | Date (mm/yy) | How many weeks did your pregnancy last? | Outcome of pregnancy (live birth, stillborn, neonatal loss, termination, miscarriage, other) | Type of delivery (vag, C/S, forceps or vacuum) | Baby's weight | Did you experience preterm labor during pregnancy? | Baby's sex | Did you or your baby experience any problems during labor or delivery? | Were there any other pregnancy complications? | Did you use anesthesia? If so, what type? (e.g. epidural) | Hours in labor | Hospital or place where baby was born | Baby's name |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 1 | | | | | | | | | | | | | |
| 2 | | | | | | | | | | | | | |
| 3 | | | | | | | | | | | | | |
| 4 | | | | | | | | | | | | | |
| 5 | | | | | | | | | | | | | |
| 6 | | | | | | | | | | | | | |
| 7 | | | | | | | | | | | | | |
| 8 | | | | | | | | | | | | | |
| 9 | | | | | | | | | | | | | |
| 10 | | | | | | | | | | | | | |

**Have you had problems with prior pregnancies not included above?**

- ☐ High blood pressure
- ☐ Pre-eclampsia
- ☐ Gestational diabetes
- ☐ Excessive bleeding after delivery
- ☐ Pelvic problems
- ☐ 3rd or 4th degree lacerations
- ☐ Incontinence
- ☐ Other: _____
- ☐ None

Please explain:

**Indicate conditions you have now or that you had in the past:**

- ☐ History of uterine fibroid or abnormally shaped uterus
- ☐ Evaluated or treated for infertility
- ☐ Abnormal Pap smear and/or human papillomavirus
- ☐ Gonorrhea
- ☐ Chlamydia
- ☐ Genital herpes
- ☐ Syphilis
- ☐ Pelvic inflammatory disease (PID)
- ☐ HIV
- ☐ None

**Have you ever had a gynecological surgical procedure such as:**

- ☐ Ectopic pregnancy or surgery on your fallopian tube
- ☐ LEEP procedure
- ☐ Cervical conization
- ☐ Cryosurgery (freezing) of cervix
- ☐ Laser treatment (other than cosmetic)
- ☐ Dilation/curettage (D&C)
- ☐ Hysteroscopy
- ☐ Cerclage
- ☐ Other/Date _____
- ☐ None

Include dates and details on above or any other gynecologic issues *(e.g. incontinence, vulvodynia, vulvar vestibulitis, or other)*?

Has your partner ever had genital herpes, HIV, viral hepatitis or other conditions that could affect this pregnancy? ..... ☐ Yes ☐ No

## Past Medical/Surgical History

**Do you have, or have you ever had, any of the following?** *(select all that apply)*

- ☐ Diabetes (high blood sugar)
- ☐ Hypertension (high blood pressure)
- ☐ Asthma
- ☐ Heart disease, mitral valve prolapse, or rheumatic fever
- ☐ Autoimmune disease (e.g. lupus, rheumatoid arthritis, or other)
- ☐ Kidney disease, kidney infection, frequent bladder infections, or other urinary tract problems
- ☐ Epilepsy or seizures
- ☐ Migraine headaches
- ☐ Stroke
- ☐ Other neurologic problems
- ☐ Depression, anxiety and/or other psychiatric condition
- ☐ Eating disorder (anorexia, bulimia, other)
- ☐ Hepatitis, liver disease, or yellow jaundice
- ☐ Blood clots in your veins, deep venous thrombosis, inflammation in the veins, phlebitis, or pulmonary embolism
- ☐ Excessive bleeding after surgery or dental work
- ☐ Anemia
- ☐ Breast problems or surgeries not mentioned above
- ☐ Thyroid problems or taken thyroid medications
- ☐ Other endocrine problems
- ☐ Major accident or suffered serious trauma
- ☐ Blood transfusion
- ☐ None

If yes, please explain:

Surgical procedures, other than obstetrical or gynecologic: ☐ Yes ☐ No

- If yes, please explain: _____

A hospital stay for a non-surgical reason other than normal delivery: ☐ Yes ☐ No

- If yes, please explain: _____

Any complications or problems from anesthesia: ☐ Yes ☐ No

- If yes, please explain: _____

Have you ever been treated for or exposed to tuberculosis? ☐ Yes ☐ No

- If yes, please explain: _____

Have you had any other infectious diseases? ☐ Yes ☐ No

- If yes, please explain: _____

**Do you have, or have you ever had, any of the following?** *(select all that apply)*

- ☐ Pernicious anemia
- ☐ Weight loss surgery
- ☐ Irritable bowel syndrome (IBS)
- ☐ Celiac disease
- ☐ Crohn's disease
- ☐ Ulcerative colitis
- ☐ MTHFR (methyltetrahydrofolate reductase) mutation
- ☐ Family history of MTHFR mutation
- ☐ Ulcers, reflux, or other gastrointestinal issues
- ☐ None

If yes, please explain: _____

Do you eat a strict vegan diet or have other dietary limits? ☐ Yes ☐ No

- If yes, please explain: _____

## Genetics and Family History

Are you interested in information about testing your blood to screen for genetic abnormalities in the baby? ☐ Yes ☐ No

- Comments: _____

Are you interested in information about amniocentesis or chorionic villus sampling to test for genetic abnormalities in the baby? ☐ Yes ☐ No

- Comments: _____

**Do you or the baby's biological father have a family history of any of the following?** *(select all that apply)*

- ☐ Brain, spinal cord, or neural tube defects (open spine, spina bifida, anencephaly)
- ☐ Congenital heart disease/defect
- ☐ Down syndrome (or other chromosome anomaly)
- ☐ Fragile X
- ☐ Hemophilia (or other inherited problems of blood clotting)
- ☐ Any genetic muscle disorders like muscular dystrophy or spinal muscular atrophy (other than MS/multiple sclerosis)
- ☐ Cystic fibrosis
- ☐ Huntington's disease
- ☐ Intellectual or mental disability or autism
- ☐ Other inherited genetic or chromosomal disorders
- ☐ None

If yes, please explain:

Are you or the biological father of the baby of Ashkenazi Jewish ancestry? ☐ Yes ☐ No

- If yes, have either of you been screened for: ☐ Tay-Sachs disease ☐ Canavan disease ☐ Familial dysautonomia
- If yes, who was screened and what were the results? _____

Are you or the biological father of the baby of African or African-American ancestry? ☐ Yes ☐ No

- If yes, have either of you been screened for sickle cell disease or trait? ☐ Yes ☐ No
- If yes, who was screened and what were the results? _____

Are you or the biological father of the baby of Mediterranean or Asian ancestry? ☐ Yes ☐ No

- If yes, have either of you been screened for: ☐ Thalassemia ☐ Sickle cell disease or trait
- If yes, who was screened and what were the results? _____

Do you or the baby's biological father have:

- ☐ Insulin dependent diabetes, phenylketonuria (PKU), congenital adrenal hyperplasia (CAH) or any other metabolic disorder not already listed above
- ☐ A prior child with a birth defect or medical condition needing surgery at birth not listed above
- ☐ Three or more miscarriages or a prior stillbirth
- ☐ A child who died shortly after birth or during childhood

If yes, please explain:

Do you have a mother or sister who had preeclampsia? ☐ Yes ☐ No

Were you born at a low weight (less than 6 pounds)? ☐ Yes ☐ No

Does anyone in your immediate family take thyroid medication? ☐ Yes ☐ No – Relationship: _____

Is there a history of other medical problems in your family that you feel might adversely affect your health or this pregnancy (such as history of blood clots in legs or lungs, diabetes, significant psychiatric illness, or other)?

## Social History

Who do you currently live with? _____

Do you agree to have a blood transfusion in order to save your life or your baby's life? ☐ Yes ☐ No

Have you traveled to an area affected by the Zika virus during this pregnancy or in the 2 months prior to getting pregnant? ☐ Yes ☐ No

Have any sexual partners traveled to an area affected by the Zika virus during this pregnancy or in the 6 months prior to getting pregnant? (If so, condoms should be used for your entire pregnancy.) ☐ Yes ☐ No

If you are currently in a relationship, do you feel safe in that relationship? ☐ Yes ☐ No

Within the past 12 months have you been physically or emotionally hurt or felt threatened by a current or former partner, caregiver, or someone you know? ☐ Yes ☐ No

- Comments: _____

Have you ever been a victim of sexual abuse or rape? ☐ Yes ☐ No

- Comments: _____

Have you experienced a death or other trauma that may affect you during this pregnancy? ☐ Yes ☐ No

- Comments: _____

Are there other medical or personal problems that we have not asked you about, which you feel might be of importance to this pregnancy? ☐ Yes ☐ No

- If yes, please explain: _____

Does anyone in your home smoke? ☐ Yes ☐ No

| Do you use any of the following: | Yes | No | Amount before pregnancy | Amount while pregnant | Years of use | Quit date |
|---|---|---|---|---|---|---|
| Tobacco | ☐ | ☐ | | | | |
| Alcohol (e.g. beer, wine, hard liquor) | ☐ | ☐ | | | | |
| Marijuana | ☐ | ☐ | | | | |
| Methamphetamine | ☐ | ☐ | | | | |
| Cocaine | ☐ | ☐ | | | | |
| Heroin | ☐ | ☐ | | | | |
| Speed | ☐ | ☐ | | | | |
| Hallucinogens | ☐ | ☐ | | | | |
| Prescription medications not prescribed to you | ☐ | ☐ | | | | |
| Recreational drugs not listed above | ☐ | ☐ | | | | |

## Other Patient Information

Who is your Ob primary care provider? _____

What is your planned hospital for delivery? _____

Patients are at the center of all that we do and we believe the best way to learn is to listen. Would you be interested in participating in future patient feedback forums to help enhance the prenatal experience within Kaiser Permanente Northwest? ☐ Yes ☐ No