Carolinas HealthCare System

Charlotte OB/GYN

PRENATAL HEALTH HISTORY QUESTIONNAIRE

Identification Data (Please Print)

Name: _____

Date of Birth: _____ Age: _____

Years of Education: _____ Occupation: _____

Married: _____ Single: _____ Separated: _____ Divorced: _____ Widowed: _____

Race: _____ Religion: _____

Partner's Name: _____

Partner's Age: _____

Partner's Occupation: _____

Partner's Work Telephone No.: _____

Your Family History

	YES	NO
Diabetes	_____	_____
High Blood Pressure	_____	_____
Heart Disease	_____	_____
Cancer	_____	_____
Neurological Problems	_____	_____
Psychological Problems	_____	_____
Blood Disorder	_____	_____
Birth Defects	_____	_____

704/446-1700

Morehead Medical Plaza
1025 Morehead Medical Dr., Suite 400
Charlotte, NC 28204

Arboretum Prof. Park
7810 Providence Rd., Suite 101
Charlotte, NC 28226

Northcross Medical Park
16455 Statesville Rd., Suite 480
Huntersville, NC 28078

Morrocroft Medical Plaza
4525 Cameron Valley Pkwy., Suite 2500
Charlotte, NC 28211

Menstrual History

First Day of Last Menstrual Period: _____

Was it a Normal Period for you? _____

Are your periods regular? Yes:_____ No: _____

How many days are there from the start of one period to the start of the next period? _____

How long do our periods last ? _____

Previous Obstetrical History

Total Number of Pregnancies (Including present pregnancy): _____

Number of Premature Babies: _____ Number of Miscarriages/Abortions: _____

Number of Living Children: _____

Did you have complications with any of your previous pregnancies Yes: _____ No: _____

Did you have any of the following problems with any of your previous pregnancies?

	YES	NO
High Blood Pressure	_____	_____
Hemorrhage	_____	_____
Diabetes	_____	_____
Cesarean Section	_____	_____
Kidney Problems	_____	_____
Anemia	_____	_____
Convulsions	_____	_____

History since Last Menstrual Period (check if positive)

Nausea	_____	Urinary Complaints	_____
Vomiting	_____	Acute Illnesses (i.e. Cold, Flu)	_____
Indigestion	_____	X-rays	_____
Constipation	_____	Accident	_____
Headaches	_____	Medications	_____
Bleeding	_____	Tobacco	_____
Abdominal Pain	_____	Alcohol	_____
	_____	Drugs (i.e. Marijuana, Cocaine)	_____

Delivery Information

Have you chosen a Pediatrician? Yes_____ No _____ If Yes, Who? _____

_____

Are you interested in childbirth education classes? _____

Prenatal Screening Questionnaire

Name _____ Chart # _____

1. Will you be 35 years or older when the baby is due? Yes ____ No ____
2. Have you, the baby's father, or anyone in either of your families ever had any of the following disorders?
   - Down syndrome (mongolism) Yes ____ No ____
   - Other chromosomal abnormality Yes ____ No ____
   - Neural tube defect, i.e., spina bifida (meningomyelocele or open spine), anencephaly Yes ____ No ____
   - Hemophilia Yes ____ No ____
   - Muscular dystrophy Yes ____ No ____
   - Cystic fibrosis Yes ____ No ____
3. Do you or the baby's father have a birth defect? Yes ____ No ____
4. In this or any previous marriage, have you or the baby's father had a child, born dead or alive, with a birth defect not listed in question 2 above? Yes ____ No ____
5. Do you or the baby's father have any close relatives with mental retardation? Yes ____ No ____
6. Do you, the baby's father, or a close relative in either of your families have a birth defect, and familial disorder, or a chromosomal abnormality not listed above? Yes ____ No ____
7. In this or any previous marriages, have you or the baby's father and a stillborn child or three or more first-trimester spontaneous pregnancy losses? Yes ____ No ____
   Have either of you had a chromosomal study?
8. If you or the baby's father are of Jewish ancestry, have either of you been screened for Tay-Sachs disease? Yes ____ No ____
9. If you or the baby's father are black, have either of you been screened for sickle cell trait? Yes ____ No ____
10. If you or the baby's father are of Italian, Greek, or Mediterranean background, have either of you been tested for B-thalassemia? Yes ____ No ____
11. If you or the baby's father are of Philippine or Southeast Asian ancestry, have either of you been tested for A-thalassemia? Yes ____ No ____
12. Have you taken any prescribed medications, over-the-counter medications, recreational drugs, or alcohol since your last menstrual period? (include IV drugs) Yes ____ No ____
13. Have you ever had chicken pox? Unsure ____ Yes ____ No ____
14. Have you or the baby's father ever had or been treated for a sexually transmitted disease, such as chlamydia, herpes, gonorrhea or syphilis? Yes ____ No ____
15. Have you or the baby's father had a positive test for AIDS or been exposed to AIDS? Yes ____ No ____
16. Are you and the baby's father related (besides marriage)? Yes ____ No ____
17. Have you or the baby's father or anyone in your families ever been diagnosed as having Phenylketonuria (PKU)? Yes ____ No ____
18. Have you or the baby's father ever had Hepatitis? Yes ____ No ____
19. Have you ever been vaccinated for Hepatitis B? Yes ____ No ____
20. Do you work in the Health Care field or in child care? Yes ____ No ____

If you have answered Yes to any of the questions, please describe here:

I have answered these questions to the best of my knowledge.

Signature _____ Date _____

Reviewed by MD _____ Date _____

Pregnancy Risk Factors

- ❒ DRUG DEPENDENCY
- ❒ HABITUAL SMOKER (ENCOURAGED TO STOP [ ])
- ❒ LESS THAN EIGHT GRADE EDUCATION
- ❒ PREGNANCY WITH FAMILY SUPPORT
- ❒ CERVICAL CONIZATION
- ❒ INCOMPETENT CERVIX
- ❒ UTERINE OR CERVICAL MALFORMATION
- ❒ CONTRACTED PELVIS
- ❒ HEIGHT UNDER FIVE FEET
- ❒ UNDERWEIGHT/OVERWEIGHT FOR HEIGHT
- ❒ UNDER AGE 18/OVER AGE 35
- ❒ UTERINE SURGERY (NON-CESAREAN)
- ❒ CESAREAN SECTION
- ❒ MULTIPLE INDUCED ABORTIONS
- ❒ HABITUAL ABORTION
- ❒ GRAND MULTIPARA
- ❒ SECOND PREGNANCY IN 12 MONTH
- ❒ FETAL DEATHS
- ❒ NEONATAL DEATHS
- ❒ PREMATURE OR LBW INFANT
- ❒ CONGENITAL OR CHROMOSOMAL ANOMALIES
- ❒ HBW INFANTS (>10 POUNDS)
- ❒ DIABETES (GESTATIONAL/INSULIN DEPENDENT)
- ❒ HEART DISEASE
- ❒ HEMOGLOBINOPATHY
- ❒ THYROID DISEASE
- ❒ ANEMIA
- ❒ EPILEPSY
- ❒ HYPERTENSION
- ❒ GENITAL HERPES
- ❒ OTHER

Filled out by _____ Date _____
Nurse

Reviewed by MD _____ Date _____