PRENATAL HEALTH HISTORY QUESTIONNAIRE
Identification Data (Please Print)

Name: ____________________________________________
Date of Birth: ____________________________ Age: ____________________________
Years of Education: ____________________________ Occupation: ____________________________
Race: ____________________________ Religion: ____________________________
Partner's Name: ____________________________________________
Partner's Age: ____________________________________________
Partner's Occupation: ____________________________________________
Partner's Work Telephone No.: ____________________________________________

Your Family History

<table>
<thead>
<tr>
<th>YES</th>
<th>NO</th>
</tr>
</thead>
<tbody>
<tr>
<td>Diabetes</td>
<td></td>
</tr>
<tr>
<td>High Blood Pressure</td>
<td></td>
</tr>
<tr>
<td>Heart Disease</td>
<td></td>
</tr>
<tr>
<td>Cancer</td>
<td></td>
</tr>
<tr>
<td>Neurological Problems</td>
<td></td>
</tr>
<tr>
<td>Psychological Problems</td>
<td></td>
</tr>
<tr>
<td>Blood Disorder</td>
<td></td>
</tr>
<tr>
<td>Birth Defects</td>
<td></td>
</tr>
</tbody>
</table>

704/446-1700
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?

<table>
<thead>
<tr>
<th>YES</th>
<th>NO</th>
</tr>
</thead>
<tbody>
<tr>
<td>High Blood Pressure</td>
<td></td>
</tr>
<tr>
<td>Hemorrhage</td>
<td></td>
</tr>
<tr>
<td>Diabetes</td>
<td></td>
</tr>
<tr>
<td>Cesarean Section</td>
<td></td>
</tr>
<tr>
<td>Kidney Problems</td>
<td></td>
</tr>
<tr>
<td>Anemia</td>
<td></td>
</tr>
<tr>
<td>Convulsions</td>
<td></td>
</tr>
</tbody>
</table>

History since Last Menstrual Period (check if positive)

<table>
<thead>
<tr>
<th>Nausea</th>
<th>Urinary Complaints</th>
</tr>
</thead>
<tbody>
<tr>
<td>Vomiting</td>
<td>Acute Illnesses (i.e. Cold, Flu)</td>
</tr>
<tr>
<td>Indigestion</td>
<td>X-rays</td>
</tr>
<tr>
<td>Constipation</td>
<td>Accident</td>
</tr>
<tr>
<td>Headaches</td>
<td>Medications</td>
</tr>
<tr>
<td>Bleeding</td>
<td>Tobacco</td>
</tr>
<tr>
<td>Abdominal Pain</td>
<td>Alcohol</td>
</tr>
<tr>
<td></td>
<td>Drugs (i.e. Marijuana, Cocaine)</td>
</tr>
</tbody>
</table>

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? Have either of you had a chromosomal study? Yes ___ No ___
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 ______________________