Moreland OB-GYN Associates, S.C.
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PREGNANCY QUESTIONNAIRE

Date:_____

A. GENERAL INFORMATION

1. Name (Last, First, Middle Initial) _____
2. Address: _____
   _____
3. Date of Birth: _____Age:_____ Primary MD _____
4. Telephone Number:
   (Home)_____(Work) _____ (Cell) _____
5. How can we contact you? ❑ Call Home ❑ Call Work ❑ Cell
   ❑ Other? _____ Can best be reached between the hours of _____

B. PATIENT PROFILE

List the people living with you. Include your children not living at home.

	Name	Relation to you	Age	Health Problems	Lives with you
1a.					❑ Yes ❑ No
1b.					❑ Yes ❑ No
1c.					❑ Yes ❑ No
1d.					❑ Yes ❑ No
1e.					❑ Yes ❑ No
1f.					❑ Yes ❑ No

2. Father of baby's name (if not living with you) _____
3. What is the highest grade of school completed? You_____ The baby's father _____
4. Please indicate the occupation of: You_____The baby's father_____
5. Have either of you ever worked around Chemicals or radiation? ❑ Yes ❑ No ❑ Unknown

C. MENSTRUAL HISTORY

1. Was this pregnancy planned? ❑ Yes ❑ No ❑ Unknown
2. Are you and the baby's father happy about this pregnancy? ❑ Yes ❑ No ❑ Unknown
3. When was the first day of your last period? _____
4. Was this period (check one:) ❑ Longer ❑ Shorter ❑ Normal
   Do you have period every month? ❑ Yes ❑ No
   If not how often _____
   Have you had any bleeding or spotting since your last period ❑ Yes ❑ No
5. Check any symptoms you've been feeling: ❑ Cramping/Pain ❑ Urinating more often ❑ Nausea / vomiting
6. If you've used birth control pills in the past, when did you take the last pill? _____
7. If you've used another method just before or since your last period, what method was it? _____
8. When was your first positive pregnancy test?_____

Comments:
_____
_____
_____

D. PREVIOUS PREGNANCIES

Child's Name	Birth Date	At how many weeks did you deliver (Normal or full term pregnancy is 40 weeks)	Delivery type	Birth Weight	Sex

2. Did you have early labor or were any babies premature or overdue? ❑ Yes ❑ No ❑ Un
3. Did you ever lose a pregnancy (by abortion, miscarriage, still birth, or ectopic-tubal pregnancy? Dates? _____ ❑ Yes ❑ No ❑ Un
4. Did you ever lose a child that was born alive? ❑ Yes ❑ No ❑ Un
   If YES, list the dates this occurred _____
5. Were any babies born breech or by caesarean section? ❑ Yes ❑ No ❑ Un
7. Did any of the babies develop yellow jaundice, infection, or any other problems during the first two weeks of life? ❑ Yes ❑ No ❑ Un
8. Did you have diabetes, high blood pressure, bleeding, depression, or any other medical problem during a previous pregnancy?
   ❑ Yes ❑ No ❑ Un If YES, list the problems _____

Please indicate if you had any of the follow complications with previous pregnancies:

Diabetes	❑ Yes	❑ No	Incompetent cervix or cerclage	❑ Yes	❑ No
Too much or too little amnotic fluid	❑ Yes	❑ No	Uterine rupture	❑ Yes	❑ No
Still born	❑ Yes	❑ No	Death of an infant	❑ Yes	❑ No
Post partum depression	❑ Yes	❑ No	Post partum hemorrhage	❑ Yes	❑ No
Placenta problems	❑ Yes	❑ No	Rupture of membrane >18 Hours	❑ Yes	❑ No
Labor >24 Hours	❑ Yes	❑ No	Labor < 3 Hours	❑ Yes	❑ No
Twin, triplet, etc.	❑ Yes	❑ No	Baby under 6lbs. or over 9lbs.	❑ Yes	❑ No
Infertility	❑ Yes	❑ No	High Blood pressure during pregnancy	❑ Yes	❑ No
Labor or rupture of membranes > 3 weeks early	❑ Yes	❑ No	Previous C/Section	❑ Yes	❑ No
			Abnormal blood screening of pregnancy (e.g. triple screen, quad screen, AFP)	❑ Yes	❑ No

Please explain all positives or any other complications:

_____

_____

Comments: _____

_____

_____

E. PAST MEDICAL HISTORY AND FAMILY HISTORY Please indicate the illness you have had, the baby's father has had or which ones run in **YOUR FAMILY.**
KEY: (M) Mother, (F) Father, (MGM) Maternal Grandmother- ie your mom's mom, (MGF) Maternal Grandfather- ie your mom's dad, (PGM) Paternal Grandmother, (PGF) Paternal Grandfather,(BR) Brother, (SIS) Sister, (SON) Son, (DAU) Daughter

	Yourself		Baby's Father		For Mother of Baby's Family only									
	Yes	No	Yes	No	M	F	MGM	MGF	PGM	PGF	BR	SIS	SON	DAU
Diabetes														
Anemia														
High Blood Pressure														
Heart Disease														
Mitral Valve Prolapse														
Varicose Veins														
Asthma / Chronic Lung Disease														
Breast Disease														
Kidney Disease/ UTI														
Liver Disease														
Blood Transfusion														
Clotting Disorder														
Bleeding Disorder														
Blood Transfusion Problems														
Neurologic/ Seizures														
Psychiatric														
Autoimmune Disorder/ Collagen Vascular Disorder (ex. Lupus, Thyroid Disease Rheumatoid Arthritis, etc)														
Twins/Multiples														

❑ If your blood type is negative, have you received Rhogam with previous pregnancies? ❑ Yes ❑ No ❑ Unknown

❑ Have you ever had anesthesia? ❑ Yes ❑ No If YES, what type? _____

❑ Have you or any member of your family had any complications related to anesthesia?
❑ Yes ❑ No ❑ If so, specify the complication _____

Comments: _____

F. SOCIAL HISTORY

❑ Yes ❑ No 1. Do you feel safe at home?
❑ Yes ❑ No 2. This past year has anyone forced you to have sexual activities?
❑ Yes ❑ No 3. Do you smoke?
4. If you smoke, how much?_____ How many years? _____
5. Have you ever smoked?_____ When did you quit? _____
6. If you drink alcohol, how many drinks per week do you consume? _____
❑ Yes ❑ No 7. Have you or your partner used any street drugs?
❑ Yes ❑ No 8. If yes, did either of you inject (shoot up) any drugs?
9. How many caffeine beverages do you ingest per day? _____

G. GYN HISTORY

1. Have you had any history of abnormal paps? ❑ Yes ❑ No When: _____
2. Have you had any history of pelvic infections or STD: ❑ Yes ❑ No
❑ Chlamydia ❑ Trichomoniasis ❑ Herpes ❑ Genital Warts ❑ Bacterial Vaginosis ❑ Gonorrhea ❑ Syphilis
When last outbreak/treatment: _____
3. Have you had any surgery or problems with your uterus(c- section, or unusual uterine shape)? ❑ Yes ❑ No
4. If you were born before 1972, were you exposed to
Diethylstilbestrol (DES) while your mother was pregnant with you? ❑ Yes ❑ No

H. SURGERIES AND HOSPITALIZATONS - If you've ever been hospitalized or ever had surgery, please complete information below:

	Reason or name	Date of operation	Location
1.			
2.			
3.			

I. INFECTION HISTORY- Please mark if you had or have been exposed to the following:

HIV:	❑ Yes	❑ No	❑ Unknown	
Hepatitis B:	❑ Yes	❑ No	❑ Unknown	
TB:	❑ Yes	❑ No	❑ Unknown	
Personal hx. of genital herpes:	❑ Yes	❑ No	❑ Unknown	
Partner hx. of genital herpes:	❑ Yes	❑ No	❑ Unknown	
Human Papilloma Virus:	❑ Yes	❑ No	❑ Unknown	
Cytomegalovirus:	❑ Yes	❑ No	❑ Unknown	
Do you have Cats?:	❑ Yes	❑ No		
Do you work with children?:	❑ Yes	❑ No		
Have you had Chicken Pox?:	❑ Yes	❑ No	❑ Unknown	❑ Tested immune in previous pregnancy
Any rash or illness since Last Menstrual Period?:	❑ Yes	❑ No	❑ Unknown	

J. GENETIC HISTORY - Mother, father, and family:

1. Are you or the baby's father members of any of the following ethnic or social groups
❑ Jewish ❑ Black/African
❑ Mediterranean (Greek, Italian, other) ❑ French - Canadian
❑ Oriental/Asian
2. Are you and the baby's father related to each other (cousins or otherwise) ? ❑ Yes ❑ No
3. Have you, the baby's father, or any members of you family or the father's family ever had any of the following birth defects:
A. ❑ Yes ❑ No Down syndrome
B. ❑ Yes ❑ No Mental retardation
C. ❑ Yes ❑ No Spina bifida, brain abnormality, anencephaly, or hydrocephaly?
D. ❑ Yes ❑ No A muscle (muscular dystrophy / myotonic dystrophy) or nerve disease?
E. ❑ Yes ❑ No Blood disorders like hemophilia, thalassemia sickle cell or others?
F. ❑ Yes ❑ No A heart defect?
G. ❑ Yes ❑ No Bone disorders?
H. ❑ Yes ❑ No Gastrointestinal abnormalities?
I. ❑ Yes ❑ No Kidney abnormalities?
J. ❑ Yes ❑ No Cystic fibrosis or any lung disease that started early in childhood?
K. ❑ Yes ❑ No Anything that you think could be a birth defect, genetic problem, (inherited or one that runs in your family or in father's family) that is not listed here?

Comments:
_____
_____
_____

4. ❑ Yes ❑ No Have you or the baby's father had a pregnancy that ended in miscarriage?
5. ❑ Yes ❑ No Have you or the baby's father had a stillborn baby or a child that died around the time of delivery or in the first year of life?

K. HEALTH MAINTENANCE- Please fill in information about these immunizations and tests:

	Date it Was Last Done	Was the Result Abnormal?
1. Flu Shot in last year		xxxxxxxxxxxxx
2. Tetanus shot		xxxxxxxxxxxxx
3. TB skin test		❑ Yes ❑ No
4. Pap Smear		❑ Yes ❑ No
5.		

L. MEDICATIONS- If you are currently taking any medication or supplements, or have taken any since you have been pregnant (either with or without prescription), please complete the information

Name of Medicine/Supplement	How Much Do You Take?	Date Started	For What Problem Do you Take It?	If Prescription, Doctor's Name and City and State
1.				
2.				
3.				
4.				
5.				

M. ALLERGIES- If you are allergic to any medicines, foods, plants, or other things, please complete

What are you allergic to?	Date of Most Recent Allergic Reaction	What kind of allergic reaction Did you have?
1.		
2.		
3.		
4.		
5.		

N. REVIEW OF SYSTEMS

1. Weight before pregnancy (fill in)____lbs. Has your weight changed since a year ago?	❑ Yes ❑ No
2. Is your thirst for liquids greater than normal?	❑ Yes ❑ No
3. Do you have a problem with headaches?	❑ Yes ❑ No
4. Do you have any problems with dizzy spells or fainting spells?	❑ Yes ❑ No
5. Any easy bleeding or bruising?	❑ Yes ❑ No
6. Any problem with presistent cough or frequent chest infections?	❑ Yes ❑ No
7. Do you get short of breath easily?	❑ Yes ❑ No
8. Any problems with nausea or vomiting, that doesn't go away?	❑ Yes ❑ No
9. Do you ever have black or bloody stool?	❑ Yes ❑ No
10. Any problems with stomach pains?	❑ Yes ❑ No
11. Any problems with diarrhea or straining when trying to have a bowel movement?	❑ Yes ❑ No
12. Any pain with urination?	❑ Yes ❑ No
13. Any problems with nerves, feeling depressed, or crying for no reason?	❑ Yes ❑ No
14. Any problems at home or work that are bothering you?	❑ Yes ❑ No
15. Have you ever had thoughts of suicide?	❑ Yes ❑ No
16. Have you ever had professional counseling (psychiatric/psychological)?	❑ Yes ❑ No
17. Any pain, lumps, leaking of fluid from your breasts?	❑ Yes ❑ No
18. Do you leak urine when you laugh, cough, sneeze, or lift heavy objects	❑ Yes ❑ No
19. Any joint, muscle, bone, or back pain?	❑ Yes ❑ No
20. Please write down any questions or list any problem you haven't already indicated elsewhere in this questionnaire:	

Patient Signature_____ Date _____

PA/RN Signature_____ Date _____

Physician Reviewed _____ Date _____