

Patient Name: _____ Date of Birth: _____ **New Pregnancy Questionnaire**

Dating Information Please allow 20-30 minutes to complete this questionnaire prior to your New OB appointment

What was the date of your last menstrual period?

About

Height * ft in

Pre-pregnancy Weight lb

What is your occupation?

Is English your native language? No Yes

What is the name of your partner/spouse?

What is the phone number of your partner/spouse?

Is the father or sperm donor of the baby 40 or older? * No Yes

Sensitive

Has your current partner ever threatened you, or made you feel afraid? No Yes

Have you ever been in an abusive relationship? No Yes

Do you feel unsafe in the neighborhood where you live? No Yes

Pregnancy History

Since becoming pregnant, have you received prenatal care from another provider? * No Yes

Is this your first pregnancy? * No Yes

Have you ever had a C-Section? No Yes

Do you feel like you had a really stressful experience with any labor and delivery from any previous pregnancy? No Yes

Did you have a forceps assisted delivery in any previous pregnancy? No Yes

Did you deliver a larger than normal infant (baby greater 8lbs,13oz) on a previous pregnancy?	No	Yes
Have you ever lost a pregnancy after 14 weeks gestation?	No	Yes
Have you ever had your uterus rupture during pregnancy, labor, or delivery?	No	Yes
Have you ever had a placental abruption or placental separation?	No	Yes
Have any of your babies been infected with Group B Strep?	No	Yes
Have you ever had a baby who was too small or growth restricted?	No	Yes
Have you had Gestational Diabetes with a previous pregnancy?	No	Yes
Have you been diagnosed with high blood pressure/preeclampsia gestational hypertension or HELLP syndrome in your previous pregnancies?	No	Yes
Were you ever admitted with pre-term contractions or diagnosed with pre-term labor in a previous pregnancy?	No	Yes
Have you had a preterm delivery at less than 37 weeks?	No	Yes
Have you ever been diagnosed with a shortened cervix in a previous pregnancy?	No	Yes
During a previous delivery, did the baby's shoulder get stuck on the way out?	No	Yes
Have you ever had a hemorrhage after delivery with a previous pregnancy?	No	Yes
Have you had postpartum depression?	No	Yes
Were you ever re-admitted to the hospital after a delivery?	No	Yes
Did you have complications during a previous pregnancy or postpartum other than those listed above?	No	Yes

Endocrine History

Do you have an overactive thyroid, or Graves disease?	No	Yes
Do you have an underactive thyroid, or Hashimoto's thyroiditis?	No	Yes
Do you have insulin-dependent or juvenile (Type 1) diabetes?*	No	Yes
Do you have adult-onset (Type 2) diabetes?*	No	Yes

Cardiovascular History

Do you have high blood pressure?*	No	Yes
Do you have ITP, history of low platelet count, or a platelet disorder?*	No	Yes
Have you ever had a blood clot in the leg (DVT) or lung (Pulmonary Embolism) or a disorder that makes your blood clot more than usual?*	No	Yes
Do you have any cardiovascular problems (heart/heart valve disease, previous heart surgery, heart defects, aortic aneurysm, arrhythmia, rapid or irregular heartbeat, or postpartum heart failure)	No	Yes

Neurological History

Do you have any type of seizure disorder?	No	Yes
Have you ever been diagnosed with a stroke (CVA, TIA)?	No	Yes
Have you ever been diagnosed with migraines?	No	Yes

Psychiatric History

Do you have problems with anxiety?*	No	Yes
Have you had a problem with depression?*	No	Yes
Have you ever been diagnosed with PTSD?	No	Yes
Have you ever been diagnosed with OCD?	No	Yes
Have you been diagnosed with a bipolar (manic-depressive) disorder?	No	Yes
Do you have schizophrenia?	No	Yes
Have you ever attempted suicide?	No	Yes
Have you ever been diagnosed with ADD (Attention Deficit Disorder) or ADHD (Attention Deficit Hyperactivity Disorder)?	No	Yes

Respiratory History

Do you currently have asthma?*	In Past	No	Yes
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Surgical History

Have you ever had any complications with anesthesia?	No	Yes
Have you ever had postoperative complications?	No	Yes
Have you had weight loss/bariatric surgery?*	No	Yes
Have you ever had a blood transfusion?*	No	Yes
Have you ever had back surgery?	No	Yes
Have you ever had abdominal surgery (other than a C-section)?*	No	Yes
Have you ever had cosmetic surgery (including breast augmentation, tummy tuck)?	No	Yes
Have you ever had transplant surgery	No	Yes

Gastroenterological History

Do you have Ulcerative Colitis?	No	Yes
Do you have Crohn's disease?	No	Yes
Do you have any history of gastrointestinal or digestive disorders other than the conditions noted above?	No	Yes

Urologic History

Have you ever had any urinary tract/urologic surgery?	No	Yes
Do you have any type of kidney/renal disease (including history of kidney stones or kidney infection)?*	No	Yes

General Medical History

Do you have antiphospholipid syndrome (APS) / thrombophilia / hypercoagulability?	No	Yes
Do you have lupus?	No	Yes
Do you have rheumatoid arthritis?	No	Yes
Do you have Sjogrens Syndrome?	No	Yes

Do you have a connective tissue disorder (Ehlers-Danlos or Marfan Syndrome)?

No Yes

Have you ever been diagnosed with or undergone treatment for Cancer?

No Yes

Gynecological History

Have you had 3 or more miscarriages?

No Yes

Have you ever needed IVF or other treatment to get pregnant?

No Yes

Have you ever had any surgery or procedures on your cervix?*

No Yes

In a previous pregnancy, have you ever had your cervix sewn or taped closed due to a weak or incompetent cervix?*

No Yes

Have you ever had a cold knife cone biopsy (conization) to remove tissue from your cervix?*

No Yes

Have you ever had a LEEP (Loop Electrosurgical Excision Procedure) performed to remove abnormal cells from your cervix?*

No Yes

Have you ever had cervix cryosurgery to freeze and destroy abnormal tissue in your cervix?*

No Yes

Have you ever been diagnosed with a uterine anomaly such as a bicornuate, unicornate, arcuate, or septate uterus?

No Yes

Do you have (or have you had) uterine fibroids (myomas)?

No Yes

Have you ever had an operation to remove a fibroid or myoma from your uterus?

No Yes

Family History

Do you or your partner have an ethnic background of Cajun/French Canadian?

No Yes

Do you or your partner have an ethnic background of Greek/Mediterranean/Italian?

No Yes

Do you or your partner have an Ashkenazi/Eastern European Jewish background?

No Yes

Has anyone in your or your partner's family had a baby with anencephaly?

No Yes

Has anyone in either your or your partner's family had Canavan Disease?

No Yes

Have you, your partner or either your or your partner's family had a chromosomal defect?

No Yes

Has anyone in either your or your partner's family had a chromosomal defect?

Do you, your partner or either your or your partner's family have sickle cell anemia?	No	Yes
Has anyone in your or your partner's family had sickle cell trait (SCT)?	No	Yes
Has anyone in your or your partner's family had a child with Down syndrome?	No	Yes
Has anyone in your or your partner's family had hemophilia?	No	Yes
Has anyone in your or your partner's family had Muscular Dystrophy?	No	Yes
Do you, your partner or either your or your partner's family have cystic fibrosis?	No	Yes
Has anyone in your or your partner's family had Huntington's Chorea?	No	Yes
Has anyone in your or your partner's family had Fragile X?	No	Yes
Has anyone in your or your partner's family had spinal muscular atrophy (SMA)?	No	Yes
Have you, your partner or anyone in your or your partner's family had von Willebrand Disease?	No	Yes
Do you, your partner or anyone in either family have any birth defects?*	No	Yes
Does anyone in either your or your partner's family have an intellectual disability?	No	Yes
Do you, your partner or either your or your partner's family have any children with special needs?	No	Yes
Has anyone in the family had pre-eclampsia?	No	Yes
Do you or your partner's family have any close relatives (parent, child, sibling) with diabetes?	No	Yes

Infection History

Have you been exposed to tuberculosis?	No	Yes
Have you had a rash or viral illness since your last menstrual period?	No	Yes
Have you ever been diagnosed with MRSA?	No	Yes
Have you ever been diagnosed with Hepatitis B?	No	Yes
Have you ever been diagnosed with Hepatitis C?*	No	Yes

Have you ever been diagnosed with any sexually transmitted disease (STD) - (Gonorrhea, Chlamydia, Trichomonas, HIV, HPV, or Syphilis?) No Yes

Have you ever had a genital herpes? No Yes

Does your partner have a history of genital herpes? No Yes

Have you ever had cold sores? No Yes

Vaccination History

Have you ever had chickenpox or been vaccinated against it? No Yes

Social History

Do you have any objections to blood transfusions? No Yes

Do you have a cat? No Yes

Do you have exposure to chemicals or radiation? No Yes

When was the last time you drank any alcohol? Never Years Ago Weeks Ago Not Since Pregnant Current

When was the last time you smoked, vaped, or used any tobacco/nicotine products? Never Years Ago Weeks Ago Not Since Pregnant Current

Do you vape or use e-cigarettes? Never Years Ago Weeks Ago Not Since Pregnant Current

When was the last time you smoked a cigarette? Never Years Ago Weeks Ago Not Since Pregnant Current

When was the last time you used marijuana, cocaine, meth, benzos, and/or opioids? Never Years Ago Weeks Ago Not Since Pregnant Current

When was the last time you used any marijuana? Never Years Ago Weeks Ago Not Since Pregnant Current

When was the last time you used any cocaine? Never Years Ago Weeks Ago Not Since Pregnant Current

When was the last time you used any methamphetamines?

Never Years Ago Weeks Ago
Not Since Pregnant Current

When was the last time you used any benzos (such as Valium, Xanax, or Ativan)?

Never Years Ago Weeks Ago
Not Since Pregnant Current

When was the last time you used any opioids?

Never Years Ago Weeks Ago Not Since Pregnant
Current

Are you exposed to second-hand tobacco smoke?

No Current

Options Counseling

Do you have questions about your options regarding this pregnancy?*

No Yes

Pregnancy History							
Total pregnancies	Full-Term Deliveries (>37 Weeks)	Premature Deliveries (20-36 wks)	Abortions	Miscarriages (<20 weeks)	Ectopic Pregnancies	Multiple Births	Living Children

Previous Pregnancy Details							
Date of Delivery	Weeks Gestation	Type of Delivery	Place of Delivery	Birth weight	Sex (M/F)	Preterm Labor?	Comments, complaints, outcomes

Other information, history, or concerns you would like your provider to know:
