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PRENATAL (GENETIC) QUESTIONNAIRE

Today's Date: _____

NAME: _____ DATE OF BIRTH: _____ AGE: _____

ALLERGIES: _____

First day of last menstrual period: _____ Last pap smear and pelvic exam: _____

Please complete the following chart and list all pregnancies, including miscarriages, ectopics, and terminations:

	Year	Vaginal or C-Section	Birth Weight	Sex	Length of Pregnancy	Complications
1.						
2.						
3.						
4.						
5.						

GENETICS SCREENING

Circle and mark accordingly, the following questions, which include patient, baby's father, or anyone in either family with:

	Patient	Baby's Father	Family Member
Italian, Greek, Mediterranean or Oriental background?			
Neural Tube Defect (Meningomyelocele, open spine, or anencephaly)?			
Down Syndrome?			
Jewish (Tay Sachs)?			
Sickle Cell Disease or Trait?			
Hemophilia?			
Muscular Dystrophy?			
Cystic Fibrosis?			
Huntington Chorea?			
Seizures?			
Mental Retardation?			
If yes, was person tested for Fragile X?	☐Y ☐N	☐Y ☐N	☐Y ☐N
Other inherited genetic chromosomal disorder?			
Will you be 35 or older at the time this baby is delivered?	☐Y ☐N		
Cleft lip, club foot, heart defects?			
Family history of twins or multiple births?			
Are the parents of this child blood-related?			

NAME: _____DATE OF BIRTH: _____

FEEDING: Breast or Bottle? _____

ANESTHESIA: None/Natural; IV Sedation; Epidural; other: _____

PEDIATRICIAN: _____

(make sure the Doctor you choose goes to the hospital where you will be delivering and is on your insurance plan)

PAST MEDICAL HISTORY

1. Any history in yourself of high blood pressure, heart disease, lung disease, liver disease, thyroid disease or diabetes?

   ❑ Yes ❑ No

   Comment: _____

2. Any previous surgery (what and when)?

   ❑ Yes ❑ No

   Comment: _____

3. Any previous hospitalizations other than child-birth or surgery mentioned above?

   ❑ Yes ❑ No

   Comment: _____

4. Any history of anesthesia complications?

   ❑ Yes ❑ No

   Comment: _____

5. Any medicines, X-ray, street drugs, alcohol, or tobacco use during this pregnancy?

   ❑ Yes ❑ No

   Comment: _____

6. Any history or known exposure to Hepatitis, HIV, TB, gonorrhea, herpes, syphilis, chlamydia, genital warts, or HPV, mycoplasma, ureaplasma?

   ❑ Yes ❑ No

   Comment: _____

7. Any problems with infertility, uterine abnormality, abnormal pap, DES exposure, or pre-term labor?

   ❑ Yes ❑ No

   Comment: _____

8. Any problems with depression, anxiety, previous postpartum blues, suicidal ideation?

   ❑ Yes ❑ No

   Comment: _____

9. List any and all childhood diseases you may have had: _____

   _____

   _____

   _____

10. List any problems you may have already had in this pregnancy:_____

    _____

    _____

    _____

11. Please list below any concerns you may have regarding this pregnancy: _____

    _____

    _____

    _____