Name _____ Age _____ Date _____

# Bellegrove OB-GYN Prenatal Questionnaire

*Welcome to Bellegrove OB-GYN. We look forward to providing your pregnancy care. In order to help us provide the best care for you, we need to learn more about your medical and social history. Please complete the following information. Feel free to ask us for clarification if you do not understand the nature of any of the questions.*

Ethnicity _____ Planned Pregnancy **No Yes** Partner supportive **No Yes**

Marital Status **Single Married** Height _____ Pre-Pregnancy weight _____

Baby's Father's Name (FOB) _____ FOB Birth Date _____

FOB Occupation _____ FOB Ethnicity _____

**Pregnancies**

Total number of pregnancies _____
Number of full term preg. _____
Number of premature preg. _____
Number of terminations _____
Number of miscarriages _____
Number of ectopic preg. _____
Number of multiples _____
Number of living children _____

**Menses**

1st day of last period (LMP)? _____
Are your periods regular? _____
How frequent are your periods? _____
Age at first period? _____
Was your last period normal? _____
Taking BCP at conception? _____
Date of 1st positive preg. test? _____
Type of test (circle one) **Blood Urine**

| **Pregnancy Number** | **1** | **2** |
|---|---|---|
| Date of delivery/Miscarriage | | |
| # Weeks of pregnancy | | |
| Hours of labor | | |
| Weight of baby | | |
| Sex of baby (circle one) | Male Female | Male Female |
| Type of delivery (circle one) | C-Section Vaginal Forceps Vacuum | C-Section Vaginal Forceps Vacuum |
| Anesthesia (circle one) | Epidural Spinal General None | Epidural Spinal General None |
| Hospital / Location | | |
| Obstetrician | | |
| Complications | | |
| Name of baby | | |

| **Pregnancy Number** | **3** | **4** |
|---|---|---|
| Date of delivery/Miscarriage | | |
| # Weeks of pregnancy | | |
| Hours of labor | | |
| Weight of baby | | |
| Sex of baby (circle one) | Male Female | Male Female |
| Type of delivery (circle one) | C-Section Vaginal Forceps Vacuum | C-Section Vaginal Forceps Vacuum |
| Anesthesia (circle one) | Epidural Spinal General None | Epidural Spinal General None |
| Hospital / Location | | |
| Obstetrician | | |
| Complications | | |
| Name of baby | | |

☐ Check if additional pregnancies charted on reverse page

**FORM A**

| **Pregnancy Number** | **5** | **6** |
|---|---|---|
| Date of delivery/Miscarriage | | |
| # Weeks of pregnancy | | |
| Hours of labor | | |
| Weight of baby | | |
| Sex of baby (circle one) | Male Female | Male Female |
| Type of delivery (circle one) | C-Section Vaginal Forceps Vacuum | C-Section Vaginal Forceps Vacuum |
| Anesthesia (circle one) | Epidural Spinal General None | Epidural Spinal General None |
| Hospital / Location | | |
| Obstetrician | | |
| Complications | | |
| Name of baby | | |

| **Pregnancy Number** | **7** | **8** |
|---|---|---|
| Date of delivery/Miscarriage | | |
| # Weeks of pregnancy | | |
| Hours of labor | | |
| Weight of baby | | |
| Sex of baby (circle one) | Male Female | Male Female |
| Type of delivery (circle one) | C-Section Vaginal Forceps Vacuum | C-Section Vaginal Forceps Vacuum |
| Anesthesia (circle one) | Epidural Spinal General None | Epidural Spinal General None |
| Hospital / Location | | |
| Obstetrician | | |
| Complications | | |
| Name of baby | | |

| **Pregnancy Number** | **9** | **10** |
|---|---|---|
| Date of delivery/Miscarriage | | |
| # Weeks of pregnancy | | |
| Hours of labor | | |
| Weight of baby | | |
| Sex of baby (circle one) | Male Female | Male Female |
| Type of delivery (circle one) | C-Section Vaginal Forceps Vacuum | C-Section Vaginal Forceps Vacuum |
| Anesthesia (circle one) | Epidural Spinal General None | Epidural Spinal General None |
| Hospital / Location | | |
| Obstetrician | | |
| Complications | | |
| Name of baby | | |

**Medications** (please include name, dosage and frequency of medication) □ **None**

1. □ Prenatal Vitamins
2. _____
3. _____
4. _____
5. _____
6. _____

**Allergies** (please include allergy and reaction) □ **No known allergies**

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____

**Medical History** (please check no or yes; if yes, please explain)

| | | | |
|---|---|---|---|
| Heart disease | □ No | □ Yes | _____ |
| High blood pressure | □ No | □ Yes | _____ |
| Respiratory problems | □ No | □ Yes | _____ |
| Neurologic problems | □ No | □ Yes | _____ |
| Diabetes | □ No | □ Yes | _____ |
| Autoimmune disorder | □ No | □ Yes | _____ |
| Kidney disease/UTI | □ No | □ Yes | _____ |
| Depression/Anxiety | □ No | □ Yes | _____ |
| Hepatitis | □ No | □ Yes | _____ |
| Pulmonary embolism | □ No | □ Yes | _____ |
| Blood clots in legs | □ No | □ Yes | _____ |
| Thyroid problems | □ No | □ Yes | _____ |
| Blood transfusion | □ No | □ Yes | _____ |
| RH sensitized | □ No | □ Yes | _____ |
| Drug/Latex allergy | □ No | □ Yes | _____ |
| Breast problems | □ No | □ Yes | _____ |
| Operations | □ No | □ Yes | _____ |
| Hospitalizations | □ No | □ Yes | _____ |
| Anesthetic problems | □ No | □ Yes | _____ |
| Uterine abnormalities | □ No | □ Yes | _____ |
| Date of last pap smear | □ No | □ Yes | _____ |
| Result of last pap | □ No | □ Yes | _____ |
| History of abnormal pap | □ No | □ Yes | _____ |
| Other | □ No | □ Yes | _____ |

**Family History** (please check no or yes; if yes, who and note if a personal history or of baby's father)

| | | | |
|---|---|---|---|
| Cardiac defects | □ No | □ Yes | _____ |
| Birth defects | □ No | □ Yes | _____ |
| Familial disorders | □ No | □ Yes | _____ |
| Diabetes | □ No | □ Yes | _____ |
| Hypertension | □ No | □ Yes | _____ |

**Social History** (please check no or yes; if yes, please explain)

| | | | |
|---|---|---|---|
| Tobacco use | □ No | □ Yes | _____ |
| Alcohol use | □ No | □ Yes | _____ |
| Recreational drug use | □ No | □ Yes | _____ |
| Domestic violence | □ No | □ Yes | _____ |
| Occupation | | | _____ |

**HISTORY**

## Genetics Screening/Teratology Counseling (please check no or yes; if yes, please explain)

Do you or your partner have a personal or family history of any of the following?

| | | |
|---|---|---|
| Down syndrome | ☐ No | ☐ Yes_____ |
| Cystic Fibrosis | ☐ No | ☐ Yes_____ |
| Thalassemia (if yes please circle one) | ☐ No | ☐ Yes_____ |
| | | **Italian Greek Mediterranean Asian Other** |
| Neural Tube Defect | ☐ No | ☐ Yes_____ |
| Congenital Heart Defect | ☐ No | ☐ Yes_____ |
| Ashkenazi Jewish Ancestry | ☐ No | ☐ Yes_____ |
| Tay-Sachs | ☐ No | ☐ Yes_____ |
| Canavan Disease | ☐ No | ☐ Yes_____ |
| Sickle cell disease or trait | ☐ No | ☐ Yes_____ |
| Hemophilia or other blood disorders | ☐ No | ☐ Yes_____ |
| Muscular Dystrophy | ☐ No | ☐ Yes_____ |
| Mental Retardation/Autism | ☐ No | ☐ Yes_____ |
| If yes, was person tested for Frag X | ☐ No | ☐ Yes_____ |
| Other inherited genetic disorders | ☐ No | ☐ Yes_____ |
| Patient or baby's father had a child with birth defects not listed? | ☐ No | ☐ Yes_____ |
| Recurrent pregnancy loss/stillborn | ☐ No | ☐ Yes_____ |
| Medications/Illicit/Recreational drugs/alcohol since LMP | ☐ No | ☐ Yes_____ |
| If yes, Agent(s) and strength/dosage | | _____ |
| Any other genetic concerns? | ☐ No | ☐ Yes_____ |

## Infection History (please check no or yes; if yes, please explain)

| | | |
|---|---|---|
| Lives with someone with TB or exposed to TB | ☐ No | ☐ Yes_____ |
| Patient or partner with genital herpes | ☐ No | ☐ Yes_____ |
| Rash or viral illness since last menstrual period | ☐ No | ☐ Yes_____ |
| History of STD, GC, Chlamydia, HPV, Syphilis | ☐ No | ☐ Yes_____ |
| At risk for chicken pox (as no history or vaccine) | ☐ No | ☐ Yes_____ |

Other _____

Have you or your sexual partner traveled to an area known to have Zika virus within the last 12 weeks?
http://wwwnc.cdc.gov/travel/page/zika-travel-information
(If Yes, please note location and travel dates) No ☐ Yes_____

_____

**GENETICS**