Patient Name: _____ **DOB:** _____ **Date:** _____
Please Print *Your 1st Visit*

PREGNANCY QUESTIONNAIRE

Congratulations on your pregnancy. We designed this questionnaire for a few reasons. These questions will aid us in completing your initial documentation, which must be completed before your initial visit. These intake questions will also allow you the time to think about your family history or talk with your relatives about important family medical history or other health factors that we would need to know about you. We are looking for diseases or disorders that can be passed from one generation to the next.

Because of our scheduling concerns, all information must be completed 72 hrs in advance of your appointment time. If you are unable to complete this form prior to your visit, we will be required to reschedule your appointment. All blanks or questions must be answered even if you mark "0" (nothing or none) or "N/A" (Not applicable). Thank you.

List any allergies to medications or foods:

Medication: **My reaction was:**

_____

_____

_____

Circle your answer

Do you have a latex allergy? Yes No
Is a blood transfusion acceptable in an emergency? Yes No
Do you need an anesthesia consult? Yes No
Are you currently taking any medications? If yes, please list all of them:

_____

_____

_____

What was the first day of your last menstrual period? _____

What was your weight before you were pregnant? _____

Which hospital do you plan on delivering at? _____

Which pediatrician do you plan on using for your baby? _____

ELITE
WOMEN'S CARE

Your birth date is: _____ Age: _____ Race: _____

Marital Status: **S**ingle **M**arried **W**idowed **Sep**arated **D**ivorced
Do you work outside the home? _____ If yes, what do you do? _____

What is your primary language? _____

Name of your husband or domestic partner: _____

His phone number/s: C _____ W _____ Other: _____

Father of baby: _____ His number/s: _____

In case of an emergency who can we contact and their number/s:
_____

_____

How many pregnancies have you had, including any miscarriages, abortions, and this one: _____

Was your last menstrual period normal? Yes No

How often did your periods come, from the first day of your period to the first day of the next period: _____

Were you on birth control pills at the time of conception at the time of conception? Yes No

How old were you when your period started? _____

Did you do a home pregnancy test? Yes No The result was? Positive or Negative

What was the date of this home pregnancy test? _____

ELITE
WOMEN'S CARE

Patient Name: _____ DOB:_____ AGE: _____

Please list all your pregnancies, including miscarriages and abortions:

Del Date Mo/Yr	Due Date	Length of Labor	Birth Weight	Sex M/F	Type of Delivery	Pain Mgmt used for Delivery	Place of Birth	Prob with pregnancy?

Your past medical history includes yourself, brothers, sisters, parents and grandparents. This does not include your husband or the father of the baby. Does anyone in your family have these disease/disorders and if they do, please list who it is, mother, grandfather etc.

Diabetes _____

Hypertension_____

Heart disease _____

Autoimmune disorders _____

Kidney disease or Urinary Tract Infection _____

Neurological problems or Epilepsy _____

Psychiatric problems _____

Depression/Postpartum depression _____

Hepatitis or Liver disease _____

Varicose veins or Phlebitis _____

Thyroid dysfunction _____

Have you had a history of trauma or domestic violence? Circle one Yes No If yes, please explain:

_____

_____

Have you ever had a blood transfusion? Circle one Yes No

ELITE
WOMEN'S CARE

Rh sensitized (are you Rh negative)? Circle one Yes No

Pulmonary disease like asthma or tuberculosis _____

Seasonal allergies _____

Drug/Latex allergies/reactions _____

Breast disorders _____

Have you ever had surgery or been hospitalized, please list and give appropriate dates:
Surgery/Hospitalization Dates

_____

_____

Have you ever had any anesthetic complications? Circle one Yes No Explain: _____

Do you have a history of abnormal pap smears? Circle one Yes No Explain: _____

Were you ever told your uterus was tilted or shaped different? Yes No Explain: _____

_____

Do you have a history of infertility? Circle one Yes No Explain: _____

Any other relevant family history? Circle one Yes No Explain: _____

Patient Name: _____ DOB: _____ AGE:_____

Do you …..	Amount per day Pre-Pregnancy	Amount per day Pregnant	How many years
Smoke?			
Drink Alcohol?			
Use Illicit or Recreational Drugs?			

ELITE
WOMEN'S CARE

Genetic screening involves your family as well as your husband/father of the baby's family. If applicable indicate who has the disease or disorder.

Neural tube defect, ie: meningomyelocele; spina bifida; or anencephaly: _____

Congenital heart defect _____

Down Syndrome _____

Tay Sachs disease (Jewish, Cajun, French Canadian background) _____

Canavan disease _____

Familial Dysautonomia _____

Sickle cell disease or trait _____

Hemophilia or other blood disorders _____

Muscular dystrophy _____

Cystic Fibrosis _____

Huntington's Chorea _____

Mental retardation/Autism, if yes, was person tested for Fragile X? Circle one Yes No

Other inherited genetic or chromosomal disorders _____

Maternal metabolic disorders, ie: Type I diabetes, PKU
_____

Do you or baby's father have a child with birth defects? _____

Have you had recurrent pregnancy loss or a stillbirth? Circle one Yes No

Please list any medications/illicit/recreational drugs/or alcohol you have taken since your last menstrual period (including supplements, vitamins, herbs or over the counter medications).

_____

_____

_____

ELITE
WOMEN'S CARE

Do you live with someone with TB or exposed to TB? Circle one Yes No

Do you or partner have a history of genital herpes? Circle one Yes No

Have you had a rash or viral illness since last menstrual period? Circle one Yes No

Do you have a history of a sexually transmitted disease, ie: gonorrhea, Chlamydia, HPV

or syphilis? Circle one Yes No **Hepatitis** - Type **B**? Type **C**? Circle one Yes No

How tall are you? _____

Please remember **we must have this completed 72 hrs before your first visit**. We left some space below, or on the back, for you to make notes on any questions or problems you might want to review with your doctor or midwife. If you have any questions please give us a call during regular office hours at **847-781-1894, Fax 847-781-1895.** If you would like to bring questions to discuss with your provider, please do so.