

Patient Name: \_\_\_\_\_ DOB: \_\_\_\_\_ Date: \_\_\_\_\_  
*Please Print* *Your 1<sup>st</sup> 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:

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*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:

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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? \_\_\_\_\_

**Your birth date is:** \_\_\_\_\_ **Age:** \_\_\_\_\_ **Race:** \_\_\_\_\_

Marital Status: **Single** **Married** **Widowed** **Separated** **Divorced**

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:

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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?** \_\_\_\_\_

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  
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?			

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).

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 **847-931-4747, Fax 847-931-9602.** If you would like to bring questions to discuss with your provider, please do so.

Edinburgh Depression Scale  
(or Edinburgh Postnatal Depression Scale)

Name \_\_\_\_\_

Date Completed \_\_\_\_\_

Please UNDERLINE the answer which comes closest to how you have felt IN THE PAST 7 DAYS, not just how you feel today.

*Here is an example, already completed:*

*I have felt happy:*

*0 Yes, all the time.*

*1 Yes most of the time.*

*2 No, not very often.*

*3 No, not at all.*

In the past 7 days:

**1. I have been able to laugh and see the funny side of things.**

- 0 As much as I always could.
- 1 Not quite so much now.
- 2 Definitely not so much now.
- 3 Not at all.

**2. I have looked forward with enjoyment to things.**

- 0 As much as I ever did.
- 1 Rather less than I used to.
- 2 Definitely less than I used to.
- 3 Hardly at all.

**3. I have blamed myself unnecessarily when things went wrong.**

- 3 Yes, most of the time.
- 2 Yes, some of the time.
- 1 Not very often.
- 0 No, never.

**4. I have been anxious or worried for no good reason.**

- 0 No not at all.
- 1 Hardly ever.
- 2 Yes, sometimes.
- 3 Yes, very often.

**5. I have felt scared or panicky for no very good reason.**

- 3 Yes, quite a lot.
- 2 Yes, sometimes.
- 1 No, not much.
- 0 No, not at all.

**6. Things have been getting on top of me.**

- 3 Yes, most of the time I haven't been able to cope at all.
- 2 Yes, sometimes I haven't been coping as well as usual.
- 1 No, most of the time I have coped quite well.
- 0 No, I have been coping as well as ever.

**7. I have been so unhappy that I have had difficulty sleeping.**

- 3 Yes, most of the time.
- 2 Yes, sometimes.
- 1 Not very often.
- 0 No, not at all.

**8. I have felt sad or miserable.**

- 3 Yes, most of the time.
- 2 Yes, quite often.
- 1 Not very often.
- 0 No, not at all.

**9. I have been so unhappy that I have been crying.**

- 3 Yes, most of the time.
- 2 Yes, quite often.
- 1 Only occasionally.
- 0 No, never.

**10. The thought of harming myself occurred to me.**

- 3 Yes, quite often.
- 2 Sometimes.
- 1 Hardly ever.
- 0 Never.

PATIENT NAME:

DOB:

## **OBSTETRIC PATIENTS and DELIVERY POLICY**

**It is our recommendation that all prenatal patients see each provider at least once during their current pregnancy. This allows each provider to become better acquainted with you in the case he or she might be at your delivery.**

**Although we make every effort to deliver our own patients, we must inform you that you may deliver with any one of our doctors or midwives. It is in your best interest to schedule at least one visit with each provider over the course of this pregnancy.**

**I read and understand that I might be delivered by anyone of the providers at Suburban Women's Health Specialists, Ltd., or an equally qualified physician appointed by my doctor in the rare case of an emergency.**

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**Signature of patient**

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**Date**

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**Witness**

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**Date**