Patient Name:_____ DOB:_____ Age:_____ Date:_____
MM/DD/YY YOUR FIRST 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 hours 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:

Are you currently taking any medications? If yes, please list all of them:

Do You Have a Latex Allergy?	**Is a Blood Transfusion Acceptable in an Emergency?**	**Do You Need an Anesthesia Consult?**

DOB: mm/dd/yy	**Age:**	**Race:**	**Marital Status:**	**Emergency Contact**
				Name:
				Phone:
Occupation:		**Education:** (last grade completed)		**Husband/Domestic Partner**
				Name:
				Phone:
Language:		**Ethnicity:**		**Father of Baby**
				Name:
				Phone:

MENSTRUAL HISTORY		**Hospital of Delivery:**	
Last Menstrual Period:	Period Monthly:		
❑ Definite	Frequency:	**Newborn Care Provider:**	
❑ Unknown	Age at First Period:		
❑ Month Known	On Birth Control Pills at Conception:	**Pre-Pregnancy**	Height:
❑ Normal Amount/Duration	Date of hCG (Home Pregnancy Test):		Weight:

LIST ALL PAST PREGNANCIES - INCLUDING: MISCARRIAGES, ABORTIONS, ECTOPICS, STILLBORNS

Date mm/dd/yy	Weeks Pregnant	Length of Labor	Birth Weight	Sex	Type of Delivery	Epidural	Place of Delivery	Preterm Labor	Comments/Complications

Patient Name:_____ DOB:_____ Age:_____ Date:_____
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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.

MEDICAL HISTORY					
	Yes/ No	Please Explain (Include Date and Treatment)		Yes/ No	Please Explain (Include Date and Treatment)
Drug/Latex Allergies/ Reactions	No		Operations/Hospitalizations (year and reason)	No	
Allergies (food, seasonal, environmental)	No		Gyn Surgery	No	
Neurologic/Epilepsy	No		Anesthetic Complications	No	
Thyroid Dysfunction	No		History of Blood Transfusions	No	
Breast Disease	No		History of Infertility	No	
Pulmonary - TB, ASTHMA	No		IVF	No	
Heart Disease	No		Uterine Abnormalities	No	
Hypertension	No		History of Abnormal Pap	No	
Cancer	No		History of Sexually Transmitted Infection	No	
Blood Disorders	No		Psychiatric Illness	No	
Anemia	No		Depression/Postpartum Depression	No	
Gastrointestinal Disorders	No		Trauma/Violence	No	
Hepatitis/Liver Disease	No				PrePreg / Preg / # Years Used
Kidney Disease/UTI	No		Tobacco (amount per day)		
Varicosities/Phlebitis	No		Alcohol (amount per week)		
Diabetes (Type 1 or 2)	No		Illicit/Recreational Drugs (uses per week)		
Gestational Diabetes	No		Relevant Family History:		
Autoimmune Disorders	No		OTHER:		
Dermatologic Disorders	No				

GENETIC SCREENING/TERATOLOGY COUNSELING INCLUDES PATIENT, BABY'S FATHER, OR ANYONE IN EITHER FAMILY WITH:			
	Yes/No		Yes/No
Thalassemia (Italian, Greek, Mediterranean, OR Asian background): MCV less than 80	No	Huntington Chorea	No
Neural Tube Defect (Meningomyelocele, Spina Bifida, or Anencephaly)	No	Mental Retardation/Autism	No
Congenital Heart Defect	No	If YES to above, was person tested for Fragile "X"?	N/A
Down Syndrome	No	Other Inherited Genetic or Chromosomal Disorder	No
Tay-Sachs (Ashkenazi Jewish, Cajun, French Canadian)	No	Maternal Metabolic Disorder (Type 1 Diabetes, PKU, etc.)	No
Canavan Disease (Ashkenazi Jewish)	No	Birth Defects Not Listed Above	No
Familial Dysautonomia (Ashkenazi Jewish)	No	Recurrent Pregnancy Loss or a Stillbirth	No
Sickle Cell Disease or Trait (African)	No	Medications (including supplements, vitamins, herbs, or otc drugs/illicit/ recreational drugs/alcohol since last menstrual period)	No
Hemophilia or Other Blood Disorders	No	If YES to above, list agent and what strength/dosage:	
Muscular Dystrophy	No		
Cystic Fibrosis	No	OTHER:	

Patient Name:_____ DOB:_____ Age:_____ Date:_____
MM/DD/YY YOUR FIRST VISIT

INFECTION HISTORY			
			Yes/ No
Live With Someone with TB or Exposed to TB			No
Patient or Partner Has History of Genital Herpes			No
Rash or Viral Illness Since Last Menstrual Period			No
Prior GBS-Infected Child			No
History of HIV			No
History of Hepatitis			No
History of STIs: (Check all that apply)			No
❑ Gonorrhea	❑ Chlamydia	❑ HPV	
❑ Syphillis	❑ PID		
OTHER:			

IMMUNIZATIONS		
	Yes/ No	Date mm/yy
TDAP or TD (Tetanus/Diphtheria)	No	
Influenza	No	
Varicella (Chicken Pox)	No	
MMR (Mumps, Measles, Rubella)	No	
Hepatitis A (when indicated)	No	
Hepatitis B (when indicated)	No	
Meningococcal (when indicated)	No	
Pneumococcal (when indicated)	No	
***If you are unsure about your immunizations, please obtain a list from your pediatrician or primary care provider.**		

Please remember **we must have this completed 72 hours 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. 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.

Any additional information from previous sections:

PLEASE COMPLETE AND RETURN FORM. **Email:** swhs2350@gmail.com **Fax:** 847-931-9602 **Mail:** Suburban Women's Health Specialists
2350 Royal Boulevard, #600
Elgin, IL 60123