ANTENATAL QUESTIONNAIRE

MOTHER OF THE BABY:_____

D.O.B.:_____/_____/_____ **AGE:**_____ **ETHNICITY:** _____

FATHER OF THE BABY:_____

D.O.B.:____/_____/_____ **AGE:**_____**ETHNICITY:** _____

MARITAL STATUS: Married / Single / Separated / Divorced / Widowed

- DO YOU LIVE WITH THE BABY`S FATHER: **YES/NO**
- ARE YOU RELATED TO BABY`S FATHER: **YES/NO**
- IF YES PLEASE SPECIFY: _____

EMPLOYMENT STATUS: Employed / Unemployed

EMPLOYER`S NAME:_____

NATURE OF JOB:_____

ARE YOU IN CONTACT WITH CHEMICALS: YES/ NO / SOMETIMES

HIGHEST LEVEL OF EDUCATION: _____

MENSTRUAL HISTORY

The first day your last menstrual periods _____/_____/____ (Definite/ Estimate / Unknown)

How often are your periods?_____How long do they last? _____

How old were you when you started having periods? _____

Were you on birth control when you fell pregnant? YES / NO

Date of first positive pregnancy test:_____/_____/_____

Have you had any significant pain? YES / NO

Have you had any bleeding since your positive pregnancy test? YES / NO

What symptoms of pregnancy have you been having?

Nausea Breast Tenderness Weight Gain Vomiting Urinary Frequency

Pelvic Pressure Other (specify)_____

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PAST PREGNANCY

How many living children do you have? How many times have you been pregnant?

How many full term deliveries? How many premature pregnancies (before 37wks)?

How many miscarriages? How many abortions have you had?

Have you ever had an ectopic pregnancy (tubal pregnancy)? YES / NO

Date of birth	How many Weeks pregnant	Birth Weight	M/F	Vaginal/ C-section	Premature labor	Problems with delivery or baby?

MEDICAL HISTORY

Do you/did you ever have any of the following medical problems?		**YES**	**NO**
1.	Diabetes		
2.	Hypertension		
3.	Heart Disease		
4.	High Cholesterol		
5.	Rheumatic Heart Disease		
6.	Heart Murmur		
7.	Chest Pain with Exertion/ Unusual shortness of Breath		
8.	Irregular Heart Beat or Palpitations		
9.	Lightheadedness or do you faint		
10.	Depression		
11.	Varicose Veins		
12.	Phlebitis/ Blood Clots in Legs or Lungs		
13.	Thyroid Problems		
14.	Rh Blood Negative Factor		

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15.	Lung Problems (Asthma)		
16.	Seasonal Allergies		
17.	Emotional Instability/ Cognitive Behaviour		
18.	Latex Allergy		
19.	Breast Problems		
20.	Ovarian Cyst		
21.	Fibroids		
22.	Abnormal Uterine Bleeding		
23.	Polycystic Ovaries		
24.	Uterine Abnormalities		
25.	DES Exposure		
26.	Have you been evaluated for infertility?		
27.	Have you had abnormal pap smear		
28.	Hepatitis/ Liver Disease		
29.	Cramping pains in Legs/ Feet		
30.	Emphysema		
31.	Lower Back Injury		
32.	Other joint Pain (explain on the back of the form)		
33.	Muscle Pain or Injury (explain on the back of the form)		
34.	Pelvic (bone) pain or injury (symphysis pubis)		

YOUR FAMILY MEDICAL HISTORY

Has anyone in your family been diagnosed with the following? (parents/ grandparents/ siblings/ children)		**YES**	**NO**
1.	Diabetes		
2.	Heart Attack/ Heart Disease		
3.	Stroke/ Blood Clots		
4.	High Blood Pressure		
5.	Cancer (breast, uterine, ovarian, colon)		
6.	Autoimmune Disease		
7.	Thyroid Disorder		
8.	Psychiatric Disorder		

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GENETIC HISTORY

Has anyone in your family or the father of the baby`s family ever had?	**YES**	**NO**
Anemia/ Blood Disorders		
Italian, Greek, Mediterranean Descent		
Jewish, French Canadian or Cajun		
African American		
Spina Bida		
Canavan`s disease		
Sickle Cell Anemia		
Tay-Sachs		
Hemophilia/ Free Bleeder		
Muscular Dystrophy		
Cyst Fibrosis		
Huntingdon`s Chorea		
Mental Retardation/ Autism		
Fragile X syndrome		
Inherited or Chromosomal Disorders		
Metabolic Disorders (PKU)		
Cleft lip/ Palate		
Deafness or Blindness at Birth		
Birth Defects		

Will you be 35 years or older when you deliver?

Have you or the father of the baby ever had any children with birth defects?

If yes please specify:_____

Do you have recurrent miscarriages or ever had a stillbirth?

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INFECTION HISTORY

Have you ever been exposed to Tuberculosis or ever had a TB test?

Do you or your partner have herpes?

Have you had any rashes or virus since your last menstrual period?

Have you ever been diagnosed with any of the following sexually transmitted infections?

Chlamydia Gonorrhea Herpes Genital Warts

HPV HIV Hepatitis B Hepatitis C Trichomonas Syphilis

Have you had chicken pox? Do you have cats in your home?

Have you received a blood transfusion? When? _____/_____/_____

Would you accept a blood transfusion if it were an urgent medical necessity?

Have you ever had any surgeries? Please list:

Surgery:_____Date:_____

Surgery:_____Date:_____

Have you ever had any biopsies?

Have you ever had any problems with anesthesia? Have you ever been hospitalized overnight?

If yes, why?_____

During this pregnancy, have you been exposed to any of the following?
Accutane, epilepsy medication, blood thinners or Lithium?
Any other prescription or non-prescription medications?
Insulin for the treatment of diabetes?
Do you use street drugs? (if yes please list all)
Do you drink alcohol? How often and what?_____
Any problems with violence or abuse?
Dispute in marriages?
Have you visited a marriage counselor?
Are you under stress?
Do you worry about the pregnancy?

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Please list any prescription or over the counter medications you have taken since your last Menstrual period: _____.

SUMMARY

Is there anything we need to know about you that has not been covered?

_____

_____

_____

Do you have any special questions for your provider?

_____

_____

_____

Patient Signature:_____**Date**_____/_____/_____