NORTHWEST FAMILY CLINICS

New Pregnancy Questionnaire

We truly look forward to caring for you and your baby.

Please answer the following questions to help us get to know you and your reproductive history a little better.

Name_____ **DOB**_____ **Date** _____

Ethnicity _____ Preferred Language _____

Marital Status (circle one)

☐ Married ☐ Single ☐ Domestic Partner ☐ Separated ☐ Divorced ☐ Widow

Occupation _____ Highest Level of Education _____

MENSTRUAL HISTORY

What is the 1st day of your last menstrual period? _____

How sure are you about the date of your last menstrual period? ☐ Definite ☐ Estimate ☐ Unknown

How often are your periods? _____

Were you on birth control when you got pregnant? _____ If so, what kind? _____

Date of 1st positive pregnancy test _____

PREGNANCY CIRCUMSTANCES

What is your living situation? (Select ***all***)

☐ With baby's father ☐ Spouse/Domestic partner ☐ Parents ☐ Relatives ☐ Friends ☐ Alone ☐ Other

Spouse/Partner/Significant Other's Name: _____

Spouse/Partner/Significant Other's Contact Phone Number: _____

Is your spouse/partner the biological father?

☐ Yes ☐ No ☐ Unknown ☐ Not Applicable ☐ Decline to answer

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At the time you became pregnant were you:

- ☐ Wanting to get pregnant?
- ☐ Wanting to get pregnant but not at this time?
- ☐ Not wanting to get pregnancy at all?

Do you plan to begin a birth control method after your baby is born? _____
If so, please circle which one(s) you prefer?

- ☐ Abstinence
- ☐ Birth control Pills
- ☐ IUD
- ☐ Tubal Ligation
- ☐ Condoms
- ☐ Natural family planning
- ☐ Nexplanon (subdermal implant)
- ☐ Vasectomy
- ☐ Spermicide
- ☐ Birth control vaginal ring
- ☐ Depo Shot (Progesterone Injection)
- ☐ Undecided

Do you plan to breastfeed this baby? _____

Is your living situation unsafe/unstable? _____

Within the last year - or since you have been pregnant - have you been hit, slapped, kicked, or otherwise physically hurt by someone? _____

Are you in a relationship with someone who threatens or physically hurts you? _____

Comments:

_____

_____

_____

_____

_____

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PAST PREGNANCIES

As a part of your prenatal care, it is important to review your pregnancy history, including abortions and miscarriages. Please complete the information below to ensure we have an accurate history in your record.

How many times have you been pregnant? _____

How many full-term deliveries have you had? _____

How many premature deliveries? _____

How many miscarriages or terminations? _____

Have you ever had twins or triplets? _____

How many living children do you have? _____

Please provide details of your past pregnancies below: (*If you need more room, write on back of this page)

	Date of delivery (M/Yr)	How many weeks pregnant at delivery?	Birth Weight	Boy or Girl?	Vaginal delivery or C-section	Pregnancy or delivery complications?
1st Pregnancy						
2nd Pregnancy						
3rd Pregnancy						
4th Pregnancy						
5th Pregnancy						
6th Pregnancy						

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PAST MEDICAL & SURGICAL HISTORY

Have ***you*** had any of the following conditions?

	Yes	No		Yes	No
Abnormal pap			Frequent bladder infections		
Anemia			Kidney stones		
Autoimmune condition			Kidney infections (pyelonephritis)		
Bleeding or excessive bruising when you are cut or injured			Asthma/Lung problems		
Blot clots			Seizure/Epilepsy		
Cancer			Migraine headaches		
Depression/Anxiety/Mental health			Thyroid problems		
Diabetes - Type 1 or 2			Major surgery		
Diabetes in pregnancy			Infertility/problems with getting pregnant		
Gallbladder disease			Ovarian cysts or poly cystic ovaries		
Heart disease			Fibroids or Uterine abnormalities		
High blood pressure			Breast problems		

Comments: _____

Have you had any surgeries? Please list approximate date and type of surgery:

_____

_____

Have you had any problem with anesthesia? _____

Have you been hospitalized overnight other than for childbirth? _____ If yes, why?

_____

_____

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INFECTION HISTORY

Have you ever been exposed to Tuberculosis or had a positive TB (Mantoux) test? _____
Do you or your partner have herpes? _____
Have you had any rashes or viruses 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 ever had Chicken Pox? _____ Had the Chicken Pox vaccine? _____

Do you have cats in your home? _____

Have you ever had a blood transfusion? _____

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

EXPOSURE RISKS

Do you smoke? _____

If yes, how much per day? _____ How long have you smoked?_____

Do you drink alcohol? _____ How many drinks per week? _____

Do you use any street drugs? _____

Marijuana/THC _____ Cocaine_____ Methamphetamine_____ Pills (list) _____

Other _____

List any prescription or over the counter medications you have taken since your last menstrual period:

_____ _____

_____ _____

_____ _____

Are you concerned about any work-related exposure risks? _____

Medication Allergies: _____

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FAMILY OR GENETIC HISTORY

Are any of the following in YOUR family or the baby's FATHER's family	YES	NO
Anemia/blood disorder		
Italian, Greek or Mediterranean decent		
Spina Bifida		
Tay-Sachs		
Jewish, French Canadian or Cajun		
Canavan's or Krabbe's disease		
Sickle Cell anemia		
Muscular dystrophy		
Cystic Fibrosis		
Huntington's Chorea		
Mental retardation or Autism		
Fragile X syndrome		
Inherited Chromosomal disorders		
Metabolic disorders (PKU)		
Cleft Lip/Palate		
Deafness/Blindness at birth		
Birth defect		
Congenital heart problems		
Other		

Do you have any of the following in *YOUR* Family	YES	NO
Diabetes		
Heart Attack		
Stroke/blood clots		
High blood pressure		
Cancer		
Autoimmune disease		
Thyroid disease		
Mental health disorder		

Will you be 35 years old or older at the time of delivering your baby? _____

Are you interested in genetic screenings? _____

Thank you! We look forward to caring for you and your growing family!

~ The Northwest Family Obstetrics Team