

*HENDERSON OB/GYN*

**PRENATAL QUESTIONNAIRE**

Patient name: \_\_\_\_\_ DOB: \_\_\_\_\_

**Family History and Genetic screening**

1. Certain genetic diseases are more common in certain ethnic groups. Please check if you or the baby's father is one of these ethnic groups.

Yes  No Eastern European Jewish ancestry  
If yes, have you had Tay-Sachs screening tests?  Yes  No  
If yes, have you had a Canavan screening test?  Yes  No

Yes  No African American  
If yes, have you had Sickle Cell screening?  Yes  No

Yes  No European Ancestry  
If yes, have you had Cystic Fibrosis screening?  Yes  No

Yes  No Mediterranean Ancestry or Southeast Asian Ancestry  
If yes, have you had screening for inherited forms of anemia such as Thalassemia?  Yes  No

2. Have you or the baby's father had a child born with a birth defect?  Yes  No  
If yes, please describe: \_\_\_\_\_

3. Did either you or the baby's father have a birth defect?  Yes  No  
If yes, please describe: \_\_\_\_\_

4. Please describe any abnormalities that have occurred in children of your family or the baby's father's family (eg, mental retardation, birth defects, deformities or inherited diseases such as Hemophilia, Muscular Dystrophy, Cystic Fibrosis or Fragile X Syndrome).

\_\_\_\_\_

\_\_\_\_\_

5. Do you have any other concerns about birth defects or inherited disorders?

\_\_\_\_\_

\_\_\_\_\_

6.  Yes  No Will you be 35 years or older at the time the baby is born?

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(OVER)

1. Have you had a temperature of 103 or greater at any time during the first two months of your pregnancy?  Yes  No
2. Do you own a cat?  Yes  No  
If yes, does your cat use a litter box?  Yes  No
3. Have you used any hot tubs, saunas or steam baths during this pregnancy?  Yes  No
4. Do you have a history of a second trimester miscarriage or an incompetent cervix?  Yes  No
5. Have you had problems with preterm labor during a previous pregnancy?  Yes  No
6. Have you been treated for infertility?  Yes  No  
List treatments: \_\_\_\_\_
7. Do you have any known abnormality or anomaly of your uterus?  Yes  No
8. Did your mother use DES when she was pregnant with you?  Yes  No
9. Do you and/or the baby's father have a history of herpes?  Yes  No  
How often do you have outbreaks/year? \_\_\_\_\_
10. Do you have a history of venereal disease, such as gonorrhea, chlamydia or HIV?  Yes  No
11. Have you had any abnormal pap smears?  Yes  No  
Dates: \_\_\_\_\_
12. Have you had a surgical procedure on your cervix such as a LOOP, LEETZ, or cone biopsy?  Yes  No
13. Do you have any close family members with tuberculosis?  Yes  No
14. Do you have a history of hepatitis, jaundice or liver disease?  Yes  No
15. Have you used cocaine, marijuana, or other drugs during this pregnancy?  Yes  No
16. Have you used alcohol during this pregnancy?  Yes  No
17. Do you smoke cigarettes?  Yes  No  
If yes, how many packs per day? \_\_\_\_\_
18. Do you have any religious objections to any form of medical treatment (ie blood transfusions)?  Yes  No
19. Do you or any family member have a history of problems with anesthesia?  Yes  No
20. I have a latex allergy.  Yes  No
21. Do you feel unsafe where you live?  Yes  No
22. In the past year, have you been threatened, hit, slapped or kicked by anyone you know?  Yes  No

I have had chicken pox or have had a vaccination for it. Please initial \_\_\_\_\_

I am aware of the risks to myself and my baby of using alcohol, illicit or recreational drugs and smoking during pregnancy. Please initial \_\_\_\_\_

List all medications taken since your last menstrual period including prescription, over-the-counter and herbal medications:

\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

Please list any surgical procedure that you have had:

\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

Please list any concerns that you have:

\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

Patient signature: \_\_\_\_\_ Date: \_\_\_\_\_ MD: \_\_\_\_\_