PREGNANCY QUESTIONNAIRE

NAME_____DATE_____
_____

1. Will you be 35 years or older when the baby is due? Yes_____
No_____

2. Have you, the baby's father, or anyone in either of your families
ever had any of the following disorders?

Downs Syndrome
Yes_____ No_____
Other chromosomal abnormality Yes_____
No_____
Neural tube defect, i.e., spina bifida or open spine, anencephaly Yes_____
No_____
Hemophilia
Yes_____ No_____
Muscular dystrophy
Yes_____ No_____
Cystic Fibrosis
Yes_____ No_____

If yes, indicate the relationship of the affected person to you
or the baby's father:
_____

3. Do you or the baby's father have a birth defect? Yes_____
No_____
If yes, who has the defect and what is it?
_____

4. In any previous marriages, have you or the baby's father had a child, born dead or alive with a
birth defect not listed in question #2 above?
Yes_____ No_____

If yes, what was the defect and who had it?
_____

5. Do you or the baby's father have any close relatives with mental
retardation?
Yes_____ No_____

If yes, indicate the relationship of the affected person to you
or to the baby's father:
_____
Indicate the cause, if known:
_____

6. Do you, the baby's father, or a close relative in either of your families have a birth defect, any
familial disorder, or a chromosomal abnormality not listed above? Yes_____
No_____

7. In any previous marriages have you or the baby's father had three or more first-trimester
spontaneous pregnancy losses or a stillborn child? Yes_____ No_____
Have either of you had a chromosomal study?
Yes_____ No_____
If yes, indicate who and the results:
_____

_____
_____

8. If you or the baby's father are of Jewish ancestry, have either of you been screened for
Tay-Sachs disease?
Yes_____ No_____

If yes, indicate who and the results:
_____

9. If you or the baby's father are African American, have either of you been screened for sickle
cell trait?
Yes_____ No_____

If yes, indicate who and the results:_____

10. If you or the baby's father are of Italian, Greek or Mediterrranean background, have either of
you been tested for Betha-thalassemia?
Yes_____ No_____

If yes, indicate who and the results:
_____

11. If you or the baby's father are of Phillippine or Southeast Asian ancestry, have either of you
been tested for Alpha-thalassemia?
Yes_____ No_____

If yes, indicate who and the results:
_____

12. Excluding iron and vitamins, have you taken any medications or recreational drugs since
being pregnant or since your last menstrual period?
Yes_____ No_____
(include non-prescription drugs)

13. Do you smoke?
Yes_____ No_____
If yes, quantity: _____(cigarettes per day)

14. Do you ever drink alcohol?
Yes_____ No_____
If yes, quantity: _____(drinks per week)

Testing for Chlamydia and gonorrhea is advised and will be performed. We are also required by state law to include HIV testing in the panel of prenatal tests. If you object to having this (or any other recommended test) performed, let us know, otherwise we assume consent.

Let me know if:
1. You want invasive genetic screening (amniocentesis or CVS) even though you are low risk.
2. You want Cesarean Section even though it may not be necessary.

15. Problems during any prior pregnancy or delivery: ( ) None

Convulsions:
Yes_____ No_____
Kidney infections:
Yes_____ No_____
Pre-eclampsia or toxemia:
Yes_____ No_____
High blood pressure:
Yes_____ No_____
Premature labor:
Yes_____ No_____
Diabetes:
Yes_____ No_____

Problems during or after any delivery: ( ) None
Blood transfusions:
Yes_____ No_____

16. Problems with any baby after delivery:
Yes_____ No_____
If yes, indicate problem:
_____

17. If you have had a previous cesarean section are you considering a vaginal birth (VBAC). Yes_____No_____

Community Hospital does <u>not</u> offer VBAC and you will need to arrange prenatal care and delivery through another facility.

18. Are you considering a home birth?
Yes_____No_____

We do not provide prenatal care for patients seeing midwives or planning home births.