BEACH CITIES MIDWIFERY AND WOMEN'S HEALTH CARE

Pregnancy Questionnaire

Welcome to Beach Cities Midwifery and Women's Health Care. We are pleased to provide prenatal care for you and are happy to be your partner for health care during your pregnancy. Our goal is to understand your health history so that we can individualize your care and provide a foundation for remaining healthy both in the pregnancy and for the future. Please help us to begin your care by completing the following questionnaire. It will give us an opportunity to identify areas that we need to discuss further and begin meeting some of the questions or concerns that you might have. Attached is also a "Notes" page that we hope you will use to write down any questions that you might have for us. That way your questions don't get forgotten! We look forward to working with you and your family during this special time.

Today's Date: ________________

Patient's Name: ____ (____________________)

First Middle Last Maiden

Date of Birth: ______ Age: _______ Height: _____ Pre-pregnant weight: ______ Religion: ________________

Occupation: ______________________________ Highest grade of school completed: __________________

☐ Single ☐ Married ☐ Partnered ☐ Separated ☐ Divorced ☐ Other ____________________

Race/Ethnicity (Mark all that apply for YOU)

☐ Hispanic	☐ White	☐ Black	☐ Chinese	☐ Japanese
☐ Korean	☐ Cambodian	☐ Laotian/Laos	☐ Vietnamese	☐ Other Southeast Asian
☐ Filipino	☐ Native American	☐ Middle Eastern	☐ Asian-East Indian	☐ Hawaiian
☐ Guamanian	☐ Samoan	☐ Unknown	☐ Other (please specify) ______________________	

Do you have a primary physician? ☐ Yes ☐ No If yes, provide name and phone number ______________________

Baby's Father:

Name: ___________________________________ Age: ______ Height: __________ Weight: _________

Occupation: ______________________________ Business Phone: _______________________________

Race: ☐ Hispanic ☐ White ☐ Black ☐ Asian ☐ Native American Other: ______________

Is he the father of your other children: ☐ Yes ☐ No ☐ N/A

Does he have children from a previous relationship? ☐ Yes ☐ No ☐ N/A

Does he have any serious illness? ____

How did you hear about the practice? ____

PERSONAL MEDICAL HISTORY:

Do **YOU** now have (or have you ever had) any of the following?
If the answer to any of the questions is yes, circle the problem and explain what and when

		NO	YES	Explain
1.	Ulcers, Colitis, Hepatitis	☐	☐	______________________________
2.	Eating disorders: Anorexia, Bulemia	☐	☐	______________________________
3.	Bladder Infection, Urinary Tract Infection (UTI) Kidney Infection (Pyelonephritis), Kidney Disease	☐	☐	______________________________
4.	Sexually Transmitted Diseases/Infections For example: Trichomonas, Genital Warts (Condyloma/HPV), Chlamydia, Gonorrhea, Herpes, Syphilis, HIV (AIDS). If history of herpes, give date of last outbreak	☐	☐	______________________________
5.	Gynecology (female) problems: Ovarian cysts, Infections of tubes or ovaries, PID (Pelvic Inflammatory Disease), Fibroids (tumors of the womb), Abnormal Pap Smear, Cryosurgery (freezing of the cervix), LEEP (Loop Electrosurgical Excision Procedure), Cone Biopsy of the Cervix	☐	☐	______________________________
6.	Lung disease: Tuberculosis, Asthma	☐	☐	______________________________
7.	Seizures, Epilepsy, Paralysis	☐	☐	______________________________
8.	Blood Diseases: Anemia, Sickle Cell Disease, Thalassemia, Bleeding Disorders, History of Blood Clots in legs or lungs	☐	☐	______________________________
9.	Allergy to any medicine	☐	☐	______________________________
10.	Operations: C-section, Abortion, D&C, Cerclage, Tubal/Ectopic, Myomectomy (removal of fibroids), Appendectomy, Laparoscopy, or <u>any other</u> operation	☐	☐	______________________________
11.	Have you been told you are a carrier for Group B Beta Streptococcus (GBS)?	☐	☐	______________________________
12.	Have you had prenatal care during this pregnancy elsewhere? If so, where ____	☐	☐	______________________________
13.	Do you have any back pain or sciatica?	☐	☐	______________________________
14.	Anything else we should know about this pregnancy or your health? Such as: history of infertility and took medication to get pregnant, I am a vegetarian or am on other special diet, I take insulin, I am a surrogate, I am not sure that I want to keep the baby, etc.	☐	☐	______________________________

MEDICAL HISTORY: Please identify the age and health status for

Your mother	Age _______	General Health ☐ Excellent ☐ Good ☐ Fair ☐ Deceased
Your father	Age _______	General Health ☐ Excellent ☐ Good ☐ Fair ☐ Deceased
Your siblings	Age _______	General Health ☐ Excellent ☐ Good ☐ Fair ☐ Deceased

Do **YOU** or **YOUR** FAMILY mother, father, sister, brother, son, daughter – (do not include the father of the baby or his family) now have (or ever had) any of the following? If the answer is YES, circle the problem(s) and explain who and what:

	No	You	My Family	Who?	Explain
1. Heart disease, Rheumatic Fever, Mitral Valve Prolapse, Heart Murmur	☐	☐	☐	____________	____________________
2. High Blood Pressure, Stroke	☐	☐	☐	____________	____________________
3. Toxemia, Pre-eclampsia, Eclampsia Pregnancy Induced Hypertension (PIH)	☐	☐	☐	____________	____________________
4. Depression, Mental Disease, Suicide	☐	☐	☐	____________	____________________
5. Thyroid Disease, Endocrine Problem	☐	☐	☐	____________	____________________
6. Diabetes, Gestational Diabetes	☐	☐	☐	____________	____________________
7. Breast or Ovarian Cancer	☐	☐	☐	____________	____________________
8. Crib Death, also know as: Sudden Infant Death Syndrome	☐	☐	☐	____________	____________________

MENSTRUAL HISTORY:

Date of FIRST day of your last menstrual period: _________________________Was it a normal period? ☐ Yes ☐ No

If NOT normal, please explain: ____

How often do you have a period? (# of days from 1st day of one period to 1st day of the next) _______ # days of bleeding? _________

Date of first positive pregnancy test, if done _________________________________

During the last 12 months, did you use

Birth Control Pills	☐ Yes ☐ No	Depo-Provera (3-month birth control shot)	☐ Yes ☐ No
Nexplanon implant	☐ Yes ☐ No	IUD/IUS	☐ Yes ☐ No

If yes to any of the above, when did you stop using the method? ____

Since your last period have you had:

☐ Nausea ☐ Vomiting ☐ Bleeding ☐ Unusual vaginal discharge ☐ Ultrasound, if yes, when _____________

PREVIOUS PREGNANCY HISTORY:

In order, list all of your pregnancies, including abortions, miscarriage, stillbirth or ectopic (tubal) pregnancy

List **ALL** In Order	Date	Where was baby born Name of facility, City and State if outside of California	Length of Pregnancy Number of months or weeks	How many hours in labor	Medication or Anesthesia Used	Outcome of pregnancy Vaginal, C/S, Forceps, Vacuum, Miscarriage, Stillbirth, Abortion, Ectopic/Tubal	Baby's Weight	Baby's Sex/ Name	Problems with Pregnancy? Labor? Birth? You had a problem? Baby had a problem? What was the problem, if any?
Example	1/00	Saddleback Memorial Medical Center	9 months	12	None, IV med or Epidural	Vaginal	7-13	Male Jack	None
1st									
2nd									
3rd									
4th									
5th									
6th									
7th									
8th									
9th									

PREGNANCY HISTORY:

Have you ever had any of the following:

1. Labor before 9 months (<36 weeks)? ☐ N/A ☐ Yes ☐ No
2. Ruptured bag of waters or fluid leaking from the vagina before 9 months? ☐ N/A ☐ Yes ☐ No
3. Have you ever been given medications or bed rest to stop contractions? ☐ N/A ☐ Yes ☐ No
4. Has your mother or sister(s) ever delivered a baby before 9 months? ☐ N/A ☐ Yes ☐ No
5. Have you ever had a postpartum hemorrhage? When? ______________ ☐ N/A ☐ Yes ☐ No
6. Have you ever had a retained placenta? When? ______________ ☐ N/A ☐ Yes ☐ No

PSYCHO-SOCIAL HISTORY:

1. Are you in a relationship where you are afraid of being hurt physically or emotionally? ☐ Yes ☐ No
2. During the past year, have you been hit, slapped, kicked, or otherwise physically hurt by someone? ☐ Yes ☐ No
3. If any of your children (or his children) have died, please explain cause of death and age? ☐ N/A ☐ Yes ☐ No

   ____

4. Are you currently experiencing difficulty in caring for your children? ☐ N/A ☐ Yes ☐ No
5. Are you currently having emotional or family problems? ☐ Yes ☐ No
6. After the birth of your children, did you experience postpartum depression? ☐ N/A ☐ Yes ☐ No
7. Are you currently experiencing problems with obtaining food or housing? ☐ Yes ☐ No
8. Have you had difficulty adjusting to this pregnancy? ☐ Yes ☐ No

WORK HISTORY: Do you:

1. Work with chemicals or dangerous substances? ☐ Yes ☐ No
2. Do <u>excessive</u> walking/standing (more than 6 hours at a time without a break) or heavy lifting (over 50 pounds)? ☐ Yes ☐ No
3. Work long hours (more than 12 hours/day or more than 50 hours/week)? ☐ Yes ☐ No
4. Commute more than 1 hour (one way) to work or school? ☐ Yes ☐ No

EDUCATIONAL NEEDS: I need more information on the following topics (mark all that apply):

☐ How to have a Healthier Pregnancy	☐ How the Baby is Growing	☐ Hospital Tour	☐ Birth Control Methods
☐ What Happens during Labor	☐ Signs and Symptoms of Labor	☐ Breast Feeding	☐ Tubal Ligation
☐ Vaginal Birth After Cesarean (VBAC)	☐ Premature Labor/Birth	☐ Bottle Feeding	☐ Vasectomy
☐ Brother/Sister Adjustment	☐ Exercise in Pregnancy	☐ Baby Care	☐ Paternity Testing

☐ Other: (please list) ____

GENERAL INFORMATION

1. Do you have a chiropractor that you see regularly? If yes, who ____________________ ☐ Yes ☐ No
2. Do you have a religious objection to receiving a blood transfusion to save your life in a medical emergency? ☐ Yes ☐ No
3. Do you plan to breast feed your baby? ☐ Yes ☐ No
4. Do you want a Tubal Ligation (a permanent surgery to prevent future pregnancy) after the baby is born? ☐ Yes ☐ No
5. Which of the following statements best describes your smoking habit?
   - ☐ I smoke now — How many cigarettes a day? _____________
   - ☐ I smoke now, but cut down since I became pregnant — Date of last cigarette? _________________
   - ☐ I quit smoking since I became pregnant
   - ☐ I smoke from time to time
   - ☐ I use to smoke but quit __________ years ago
   - ☐ I have never smoked
6. Which of the following statements best describes your drinking habit?
   - ☐ I drink alcoholic beverages (wine, beer, hard liquor). What? ________________ How much? _________________
   - ☐ I drink alcoholic beverages, but cut down since I became pregnant. Date of last drink ______________________
   - ☐ I quit drinking since I became pregnant.
   - ☐ I drink from time to time.
   - ☐ I don't drink.
   - ☐ I have never consumed alcoholic beverages.
7. Which of the following statements best describes your recreational drug habit (cocaine, PCP, marijuana, speed, LSD, heroin)?
   - ☐ I use recreational drugs — Which ones? ____
   - ☐ I use recreational drugs, but cut down since I became pregnant. Date of last use: ______________________
   - ☐ I quit the use of recreational drugs since I became pregnant.
   - ☐ I use drugs from time to time
   - ☐ I don't use recreational drugs
   - ☐ I have never used recreational drugs
8. Are you concerned that alcohol or drugs you have used during this pregnancy may have harmed your baby? ☐ Yes ☐ No
9. Are you concerned about the use of drugs/alcohol of someone close to you? ☐ Yes ☐ No
10. If your partner smokes, drinks alcoholic beverages, or uses recreational drugs, please describe his habit(s): __________
____
11. Do you have cats? ☐ Yes ☐ No; If yes, do you change the litter box? ☐ Yes ☐ No
12. Have you or your partner travelled outside of the United States in the past 6 months where Zika virus has been reported? ☐ Yes ☐ No

SEXUAL HISTORY/RISKS FOR HIV:

1. Are your sexual partners ☐ men ☐ women ☐ both
2. Have you ever had an abnormal pap smear? ☐ Yes ☐ No
   If yes, when? ______________ Other testing or treatment completed? __________________________________
3. Have you, or your partner, ever had a Sexually Transmitted Disease (STD)? ☐ Yes ☐ No
   Such as: Trichomonas, Genital Warts (Condyloma/HPV), Chlamydia, Gonorrhea, Herpes, Syphilis, etc.
4. Have you, or your partner, ever had a blood transfusion? ☐ Yes ☐ No
5. Have you, or your partner, had more than two sexual partners in your life? ☐ Yes ☐ No
6. Have you, or your partner, ever had rectal/anal sex? ☐ Yes ☐ No
7. Have you, or any of your sexual partners, ever injected drugs or had sexual relations with gay or bisexual men, or prostitutes? ☐ Yes ☐ No
8. Do you or your partner have the HIV (AIDS) virus? ☐ Yes ☐ No

GENETIC QUESTIONNAIRE:

1. Please list ALL medications taken since your last period (prescription and non-prescription): including vitamins and natural or herbal preparations ____
2. Will you be 35 years or older when your baby is born? ☐ Yes ☐ No
3. In any previous marriages, have you or the baby's father or a previous partner had
   a stillborn child? ☐ Yes ☐ No
   Three or more first trimester spontaneous (miscarriage) pregnancy losses? ☐ Yes ☐ No
4. Are you and the father of the baby related by blood (cousins, etc)? ☐ Yes ☐ No
5. If you, or the baby's father are of the following racial background(s) have you ever been tested for: ☐ N/A

Ancestry or Racial Background	You	Baby's Father	Has testing been done?	You	Baby's Father
Eastern European Jewish, French Canadian, Cajun			Tay-Sachs Disease		
Italian, Greek, Mediterranean			Beta Thalassemia		
Southeast Asian, Philippine			Alpha Thalassemia, Beta Thalassemia		
Black/African American			Sickle Cell Trait/Disease, Thalassemia		

6. Have you ever had blood testing for the following inherited conditions?
   Cystic Fibrosis: ☐ Yes ☐ No Tay Sachs disease: ☐ Yes ☐ No Sickle Cell Disease: ☐ Yes ☐ No
7. Are you interested in Genetic Counseling or Prenatal Diagnosis? (CVS or Amniocentesis) ☐ Yes ☐ No
8. Have you had genetic counseling or genetic screening in the past? ☐ Yes ☐ No
9. Have either of you had a chromosomal study? If YES, indicate who and the results: ☐ Yes ☐ No

   ____
10. Does anyone in the immediate family now have (or ever had) any of the following conditions?
    (Yourself, Father, Mother, Sisters, Brothers, Father of the baby, his children, your children)

	No One	You	Baby's Father	Your Children	Other Family Who?	Explain
Down Syndrome (mongolism)						
Other chromosome problem						
Spina Bifida (open spine)						
Anencephaly (no brain)						
Hemophilia (bleeding disorders)						
Cystic Fibrosis						
Muscular Dystrophy (muscle disease)						
Cleft Lip or palate (Harelip)						
Skeleton Disorders ("little person")						
Mental Retardation						
Childhood Heart Defect (or at birth)						
Congenital Dislocation of Hip						
Other inherited genetic disease such as: Deafness, Huntington's Chorea, Neurofibromatosis, FragileX Syndrome, Polycystic Kidney Disease, Congenital Adrenal Hyperplasia						
Other Birth Defects						

DEPRESSION SCREENING: In the past 2 weeks, how often have you been bothered by:

1. Little interest or pleasure in doing things?
   ☐ Nearly every day ☐ More than half the days ☐ Several days ☐ Not at all
2. Feeling down, depressed or hopeless?
   ☐ Nearly every day ☐ More than half the days ☐ Several days ☐ Not at all

NUTRITION HISTORY:

1. Do you have any special diet or dietary restrictions ☐ Yes ☐ No
   If yes, please describe ______________________________
   ____
   ____
2. Are you vegetarian or vegan? ☐ Yes ☐ No
   If yes, circle the appropriate diet you follow
3. Are you having/did you have any problems with vomiting that prevents you from having adequate nutrition? ☐ Yes ☐ No
4. How much weight do you plan to gain in this pregnancy? ________ How much weight did you gain with you previous pregnancy(ies)? (if this is your first pregnancy, leave blank) ______________
5. Please provide us with a list of all food and drink that you consumed in the **last 24 hours**. As much as possible identify the portions eaten and any supplements, such as, mayonnaise on a sandwich, gravy on rice, etc. This will help us to provide you with some guidance for nutrition during this pregnancy. Include breakfast, lunch, dinner and any mid-meal snacks.

Breakfast: ______________________________

Mid-morning: ______________________________

Lunch: ______________________________

Mid-afternoon: ______________________________

Dinner: ______________________________

Late evening: ______________________________