Las Vegas OB/GYN Women's Care

PRENATAL QUESTIONNAIRE

Age _____ **YES** **NO**

First day of last menstrual period (LMP) _____

1. Have you, the baby's father, or anyone in either family had any of the following? ☐ ☐

Circle those that apply Down Syndrome (mongolism), neural tube defects (e.g. spina bifuda or open spine), cystic fibrosis, muscular dystrophy, hemophilia, or any chromosomal abnormality.

Who ? _____

2. Do you or the baby's father have any birth defects? ☐ ☐

Explain: _____

3. With any previous partners, was there ever a child born with a birth defect or born dead? ☐ ☐

Explain: _____

4. What is your primary heritage, race, or background ? _____

The baby's father's ? _____

5. Have you ever been tested for any of the following? Check all that apply.

Tay-Sach's Disease (Jewish ancestry-Asiatic)	☐	☐
Sickle Cell Disease (African-Americans)	☐	☐
A-Thalessemia (Philippines or Southeast Asian)	☐	☐
B-Thalessemia (Italian, Greek, or Mediterranean)	☐	☐

What were the results ? _____

6. Have you had three or more *consecutive* , spontaneous first-trimester miscarriages? ☐ ☐

When and how many weeks ? _____

_____

7. What prescription and over-the-counter medications have you had since your last menstrual period ? _____

_____

8. Have you used any recreational drugs, including tobacco and alcohol, since your last period ? ☐ ☐

What, when, & how much ? _____

_____

I have read and answered the above questions to the best of my knowledge.
My additional concerns include the following:

NAME (Print): _____

SIGNATURE:_____ DATE: _____

Las Vegas OB/GYN Women's Care

1. IDENTIFICATION DATA (Please Print)

(NOTE: Complete the rest of this section only if you are asked to or if any changes have occurred since your last visit. Otherwise skip to part 2)

Name : _____ **Home #:** _____ **Cell #** _____

Address _____
Street Number City State Zip code

Circle One:

Married	Divorced
Single	Widowed
Separated	

Date of Birth _____ Religion_____ Race _____ Last Grade Completed _____

Social Security No _____ Medicaid or Welfare No (If any) _____ Health Insurance _____ Policy No: _____

Employer _____ Address _____ Telephone No: _____

Husband's Name _____ Date of Birth _____ Blood Type _____ Race _____ Religion _____

Husband's Employer _____ Address _____ Telephone No: _____
City State

2. FAMILY ILLNESSES

Please mark and "X" where you , your husband, children and blood relatives have had any of of the following illnesses. Examples are shown in parentheses ( )

	Yourself	Husband	Children	Your Blood Relatives	Husband's Blood Relatives
Blood disease (hemophilia, sickle cell anemia)					
Bones or Joint disorders					
Malignancies (cancers)					
Chronic Lung disease (asthma, bronchitis)					
Hearing defects					
Glandular Disease (diabetes, thyroid disease)					
Heart Trouble (rheumatic fever, angina)					
Kidney or Urinary disease					
Hypertension (high blood pressure)					
Muscle disease (weakness, poor control)					
Nerve disease (cerebral palsy, epilepsy)					
Psychiatric condition					
Tuberculosis					

Other: _____

☐ No known illnesses

3. ALLERGIES

Check any of the following medications that you are allergic or react poorly to

- ☐ Local anesthetic (Xylocaine)
- ☐ Antibiotics
- ☐ Penicillin
- ☐ Sulfa Drugs
- ☐ Sedatives tranquillizers

Others: _____

☐ No known allergies

4. MEDICATIONS

Please list **ALL** medications you are now taking or have taken in the past 6 months

☐ No medications being taken

5. HOSPITALIZATIONS (Not for normal pregnancies)

If you have ever been hospitalized for any serious medical illness or operation, write in your most recent hospitalizations below

☐ Check here if you have never been hospitalized for any illness or operation

Year	Illness or Operation	Year	Illness or Operation

6. PREGNANCY HISTORY : Include induced abortions, miscarriages, and still births

☐ Check here if you have had more than eight pregnancies

NO	Delivery Date Month/Year	Baby's Sex	Weeks Pregnant	Hours in labor	Type of Delivery (Normal) (Breech) (Cesarean)	Baby's Weight	Complications such as abortion, hypertension, stillbirth, and infant death
1						lb oz	
2						lb oz	
3						lb oz	
4						lb oz	
5						lb oz	
6						lb oz	
7						lb oz	
8						lb oz	