

Patient Name

Date

**PORTLAND OB/GYN ASSOCIATES, PC
PRENATAL HISTORY QUESTIONNAIRE**

Having a healthy baby is a special event. Once a baby is born, families take certain precautions to ensure the baby's health and safety.

QUESTIONNAIRE

The following questions will help in the care of your pregnancy. Please answer these questions as well as you can. All answers will remain private. If you need help answering the questions, please ask your health care provider. The first question relates to your family history. The next 8 questions will be about you, your baby's father and both your families. When thinking about your families, please include your child (or unborn baby), mother, father, sisters, brothers, grandparents, aunts, uncles, nieces, nephews or cousins.

- Yes No 1. Will you be 35 years or older when the baby is due? Age when due: _____
- Yes No 2. Are you and the baby's father related to each other (i.e. cousins)?
- Yes No 3. Have you had three or more pregnancies that ended in miscarriage?
- Yes No 4. Have you or the baby's father had a stillborn baby or a baby who died around the time of delivery?
- Yes No 5. Do either you or the baby's father have a birth defect or genetic condition such as a baby born with an open spine (spina bifida), a heart defect, or Down's Syndrome?
- Yes No 6. Does anyone in your family or anyone in the baby's father's family have a birth defect or condition that has been diagnosed as genetic or inherited, such as open spine (spina bifida), a heart defect or Down's Syndrome?
- Yes No 7. Where your ancestors came from may sometimes give us important information about the health of your baby. Are you or the baby's father from any of the following ethnic/racial groups. Jewish, Black, Asian, Mediterranean (Greek, Italian)?
- Yes No 8. Have you or the baby's father ever been screened to see if you are carriers of the gene for any of the following: Tay-Sachs, Sickle Cell, Thalassemia?

Sometimes, the unborn baby can be exposed to outside factors that can cause birth defects. The next 8 questions will give us important information about possible exposure to the baby.

- Yes No 9. Have you had any x-rays during this pregnancy?
- Yes No 10. Have you had any alcohol during this pregnancy?
- Yes No 11. Prior to your pregnancy, how often did you drink alcohol beverages?
 Every day Less than once a month
 At least once a week, not daily I do not drink alcoholic beverages.
 At least once a month, not weekly
12. Prior to your pregnancy, about how many alcoholic beverages did you usually have per occasion? (1= one can of beer, one wine cooler, one glass of wine, or one shot of liquor)
 3 or more
 1 too 2
 I do not drink alcoholic beverages

Yes No 13. Have you taken any over-the-counter, prescription or "street" drugs during this Pregnancy? If Yes, list drugs.

Yes No 14. Have you ever sought and/or received treatment for alcohol or drug problems? If yes, how long ago? _____

Yes No 15. Do you think you are at increased risk of having a baby with a birth defect or genetic disorder?

Yes No 16. At any time during the first two months of your pregnancy. Have you had a rash or a fever of 103°F or greater?

A test for HIV is strongly recommended for all pregnant women, regardless of your responses to the next questions. The test is done automatically as part of the OB panel. There are two reasons to be tested: (1) New medications are available to reduce the chance of an infected mother passing HIV to her baby; and (2) Most women do not know if they are infected with HIV until late in the disease. Sometimes, other infections can put you and your baby at risk. The following questions will help your health care provider determine other areas for counseling and evaluation.

Yes No 17. Have you or your sexual partners ever had a sexually transmitted disease (STD or VD) such as chlamydia, gonorrhea, syphilis or herpes?

Yes No 18. Have you ever had a serious pelvic infection or pelvic inflammatory disease (PID)?

Yes No 19. Do you think any of your male sexual partners have ever had sex with other men?

Yes No 20. Have you or your sexual partners ever used IV street drugs?

Yes No 21. Have you had sex with two or more partners in the last twelve months?

Yes No 22. Do you think any of your sexual partners may have HIV or AIDS?

Yes No 23. Have you or your sexual partners ever had a blood transfusion?

How safe you feel in your daily living gives us important information about risks to you and your baby. Please answer these questions as well as you can. All answers will remain private.

Yes No 24. Do you feel safe....
in your personal relationship?

Yes No within your home?

Yes No in your own neighborhood?

Yes No Other (specify) _____

Yes No 25. Have you ever had your feelings repeatedly hurt, been repeatedly put down, or experienced other kinds of hurting?

Yes No 26. Are you being or have you ever been hit, slapped, kicked, pushed or otherwise physically hurt? If yes, by whom?

Husband Family Member Ex-husband Partner Other (specify) _____

Yes No 27. Are you experiencing or have you ever experienced uncomfortable touching or forced sexual contact? If yes, by whom?

Husband Family Member Ex-husband Partner Other (specify) _____