

Patient Name: _____ Age: _____ Marital Status: _____

Occupation: _____ Can we discuss your pregnancy with your partner? Yes No

BP: _____ BMI: _____ EPDS: _____

CURRENT PREGNANCY

When was the 1st day of your last period (LMP): _____

Conception Method: _____

Spontaneous IVF IUI Donor Egg Donor Sperm

PREGNANCIES

How many of the following have you had:

Pregnancies: _____ Living children: _____

Miscarriages: _____ Terminations: _____

Ectopic pregnancies: _____

For each previous pregnancy, please complete the following:

Year of delivery, gestational age (GA) at delivery, type of delivery (vaginal/Cesarean/vacuum), birth weight, any complications.

G1 - Year _____ GA _____ Birth weight _____

Type of Delivery: vaginal Cesarean vacuum

Complications: _____

G2 - Year _____ GA _____ Birth weight _____

Type of Delivery: vaginal Cesarean vacuum

Complications: _____

G3 - Year _____ GA _____ Birth weight _____

Type of Delivery: vaginal Cesarean vacuum

Complications: _____

G4 - Year _____ GA _____ Birth weight _____

Type of Delivery: vaginal Cesarean vacuum

Complications: _____

G5 - Year _____ GA _____ Birth weight _____

Type of Delivery: vaginal Cesarean vacuum

Complications: _____

Other: _____

MEDICAL HISTORY

Have you ever had: Yes No Comments (optional)

Stroke _____

Blood clots (DVT) _____

Heart disease _____

Hypertension _____

Thyroid disease _____

Liver disease _____

Cancer _____

Diabetes _____

Migraine headaches _____

Epilepsy/seizures _____

Anemia _____

Kidney disease _____

Autoimmune disease _____

Inflammatory bowel _____

Other: _____

SURGICAL HISTORY

Please list ALL previous surgeries you have had:

MENTAL HEALTH

Have you ever had: Yes No Comments (optional)

Depression _____

Anxiety _____

Bipolar disorder _____

Postpartum Pregnancy/ mood disorder Yes No

Other: _____

SEXUAL AND REPRODUCTIVE HEALTH

Do you have history of any of the following:

Yes No

Genital Herpes (HSV)

Chlamydia/Gonorrhea

Recurrent Bacterial Vaginosis

Pelvic Inflammatory Disease

Hx of abnormal PAP

MEDICATION

Please list ALL medications you are currently taking:

Are you taking prenatal vitamins? Yes No

ALLERGIES

Please list any and all allergies:

FAMILY HISTORY

Do any relatives have the following conditions?

Yes No Comments (optional)

Diabetes _____

Hypertension _____

Heart disease _____

Genetic disorders _____

Birth defects _____

Intellectual disabilities _____

Twins or multiples _____

Pregnancy complications _____

Patient Name: _____

Please answer the relevant questions

GENETICS COUNSELING

Are you interested in meeting with a genetic counselor to review available screening and testing options in a pregnancy?

Insurance may or may not cover additional testing.

Yes No

Have you seen a genetic counselor in a previous pregnancy?

Yes No

Is your partner/donor (sperm producer) over the age of 40 at the time of conception?

Yes No

Do you or your partner have a personal or family history of a chromosomal condition (i.e. Down syndrome, microdeletion syndrome)?

Yes No

Do you or your partner have a personal or family history of a structural birth defect (i.e. cardiac defect, clubfoot)?

Yes No

Do you or your partner have a family history of an inherited condition (i.e. cystic fibrosis, muscular dystrophy, hemophilia, sickle cell, or fragile X)?

Yes No

Do you have a history of recurrent pregnancy losses (≥ 2)?

Yes No

ANCESTRY

Check all that apply:

- African or African American
- Ashkenazi Jewish
- Asian
- Caucasian/European
- Hispanic/Latino
- Mediterranean
- Native American
- Pacific Islander
- Other: _____

LIVING SITUATION AND SAFETY SCREENING

Do you have stable housing? Yes No

Do you have reliable transportation to appointments?

Within the past 12 months, have you worried that your food would run out before you got money to buy more?

Are you afraid of your partner or anyone else?

Do you feel safe in your current relationship?

SUBSTANCE USE/ EXPOSURE

Workplace exposures to chemicals/radiation Yes No

Marijuana or other recreational drugs

Drink alcohol

Use e-cigarettes/vape

Smoke tobacco

INFECTIOUS DISEASE SCREENING

Have you ever been diagnosed with any of the following:

HIV Yes No

Hepatitis B or C? Yes No

Syphilis Yes No

Have you had chickenpox or received the varicella vaccine?

Yes No Unknown

Have you had rubella or received the MMR vaccine?

Yes No Unknown

Have you received the flu vaccine this season?

Yes No Unknown

OTHER

Please share any other relevant information

