Newton-Wellesley
OBSTETRICS & GYNECOLOGY, P.C.

INITIAL PRENATAL VISIT - First Page

Label

Patient Name: _____DOB:_____ Age: _____ Marital Status: _____

Occupation: _____ Can we discuss your pregnancy with your partner?__Yes __No

Hight:_____

*Partners Name and Contact #:*_____

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 of **your** relatives have the following :

	Y	N	(Immediate FAM)
Diabetes			_____
Hypertension			_____
Heart disease			_____
Genetic disorders			_____
Birth defects			_____
Intellectual disabilities			_____
Twins or multiples			_____
Pregnancy complications			_____

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INITIAL PRENATAL VISIT - Second Page

Label

Height:_____

Patient Name: _____ DOB:_____

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 If yes, please specify: _____

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 If yes, please specify: _____

Do you have a history of recurrent pregnancy losses (≥2)?
____ Yes ___No If yes, please specify: _____

ANCESTRY

Check all that apply:

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

_____

OFFICE USE:
Weight:_____ Height:_____

BP:_____ EPDS:_____

LIVING SITUATION AND SAFETY SCREENING

	Yes	No
Do you have stable housing?	___	___
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

	Yes	No
Workplace exposures to chemicals/radiation	____	____
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

_____
_____
_____
_____
_____