

The Maternal Fetal Center

HISTORY QUESTIONNAIRE



DATE: _____

Patient Name: _____ Date of birth: _____

Partner's Name: _____ Date of birth: _____

Last period date: _____

What medications are you currently taking? _____

What drug/other allergies do you have? _____

List all previous pregnancies below. (Include all births, miscarriages and abortions. Use back of page if needed)

Year	Vaginal or cesarean birth	Birth weight	Problems - pregnancy, delivery or baby?

Did you have medical illnesses in the past? YES _____ NO _____. List below.

Year	Name/type of illness	Medication taken?	Resolved /still a problem/other?

Have you ever had a surgical procedure? YES _____ NO _____. List all surgeries below.

Year	Name of illness	What kind of surgery did you have?	Resolved?

Circle the infections that you have had.

Syphilis Gonorrhea Chlamydia Herpes HPV Hepatitis
 Abnormal Pap smear Uterine or Cervical surgeries LEEP Cone biopsy

OTHER _____

Do you Drink alcohol ___ YES ___ NO
 Smoke cigarettes ___ YES ___ NO
 Use recreational drugs ___ YES ___ NO

If yes, describe when and how much. _____

Are you exposed to toxins at work or elsewhere ? ___ YES ___ NO

If yes, explain. _____

Are you currently having any problems with the pregnancy? Circle all that apply.

Headache Visual problem Abdominal pain Contractions
 Nausea Swelling Vaginal bleeding Leakage of fluid
 Vomiting Pelvic pressure

Describe illnesses that your family members have:

Mother _____ Father _____
 Sister _____ Brother _____
 Maternal grandmother _____ Paternal Grandmother _____
 Maternal grandfather _____ Paternal Grandfather _____

Patient Signature _____

The Maternal Fetal Center

HISTORY QUESTIONNAIRE



PATIENT NAME: _____

THIS SIDE REFERS TO YOU & YOUR FAMILY.

THIS SIDE REFERS TO YOUR PARTNER & HIS FAMILY.

<p>Ethnic background or ancestry?</p> <p><input type="checkbox"/> African-American</p> <p><input type="checkbox"/> Asian</p> <p><input type="checkbox"/> Caucasian</p> <p><input type="checkbox"/> Northern European</p> <p><input type="checkbox"/> Mediterranean (Greek/Italian)</p> <p><input type="checkbox"/> French Canadian</p> <p><input type="checkbox"/> Hispanic</p> <p><input type="checkbox"/> Jewish Other _____</p>	<p>Ethnic background or ancestry?</p> <p><input type="checkbox"/> African-American</p> <p><input type="checkbox"/> Asian</p> <p><input type="checkbox"/> Caucasian</p> <p><input type="checkbox"/> Northern European</p> <p><input type="checkbox"/> Mediterranean (Greek/Italian)</p> <p><input type="checkbox"/> French Canadian</p> <p><input type="checkbox"/> Hispanic</p> <p><input type="checkbox"/> Jewish Other _____</p>
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	YES	NO	RELATIONSHIP		YES	NO	RELATIONSHIP
CLEFT LIP/PALATE				CLEFT LIP/PALATE			
HEART DEFECTS				HEART DEFECTS			
OPEN SPINA BIFIDA				OPEN SPINA BIFIDA			
MUSCLE DISEASE				MUSCLE DISEASE			
MUSCULAR DYSTOPHY				MUSCULAR DYSTOPHY			
MENTAL RETARDATION				MENTAL RETARDATION			
DOWN SYNDROME				DOWN SYNDROME			
CYSTIC FIBROSIS				CYSTIC FIBROSIS			
KIDNEY DISEASES				KIDNEY DISEASES			
SICKLE CELL				SICKLE CELL			
HEMOPHILIA				HEMOPHILIA			
THALASSEMIA				THALASSEMIA			
OTHER				OTHER			

Have you had more than one miscarriage? ___ NO ___ YES

If yes, how many? _____.

Have you ever had a stillborn baby after the ninth month of pregnancy? ___ NO ___ YES.

If yes, explain _____.

Have you ever had a child with a birth defect? ___ NO ___ YES

If yes, explain _____.

Is your partner a blood relative? _____.

If yes, how are you related? _____.

Do you have diabetes? ___ NO ___ YES

Do you have epilepsy or seizures? ___ NO ___ YES

Do you take any medications on a regular basis? _____.

Patient Signature _____

PEDIGREE: NO / YES - On reverse side