SWEDISH
MEDICAL GROUP

Patient Name _____ Date

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. The unborn child deserves similar care.

The following questions will help in the care of your pregnancy. Please answer these questions as well as you can. If you need help answering the questions, please ask your health care provider. The first questions relate to you. The next set of 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 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 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 either of you are carriers of the gene for any of the following: Tay-Sachs, Sickle Cell, Thalassemia, or Cystic Fibrosis?

Yes No 9. Do you think you are at increased risk of having a baby with a birth defect or genetic disorder?

If yes, which defect or disorder? _____

Why do you think you are at increased risk? _____

Yes No 10. At any time during the first two months of your pregnancy, have you had a rash or a fever of 103° F or greater?

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 11. Have you had any x-rays during this pregnancy?

Yes No 12. Have you had any alcohol during this pregnancy?

13. Prior to your pregnancy, how often did you drink alcoholic beverages?
☐ Every day
☐ At least once a week, not daily
☐ At least once a month, not weekly
☐ Less than once a month
☐ I do not drink alcoholic beverages

14. 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 to 2
☐ I do not drink alcoholic beverages

PRENATAL HISTORY QUESTIONNAIRE - 2

_____
Date

15. Which statement best describes your smoking status?
☐ I have never smoked or have smoked less than 100 cigarettes in my lifetime.
☐ I stopped smoking before I found out I was pregnant, and I am not smoking now.
☐ I stopped smoking after I found out I was pregnant, and I am not smoking now.
☐ I smoke some now, but have cut down on the number of cigarettes I smoke since I found out I was pregnant.
☐ I smoke regularly now, about the same as before I found out I was pregnant.

Yes No 16. Have you taken any over-the-counter, prescription, or "street" drugs during this pregnancy? If yes, list drugs.

_____

_____

Yes No 17. Have you ever sought and/or received treatment for alcohol or drug problems? If yes, how long ago? _____

A test for HIV is strongly recommended for all pregnant women, regardless of your responses to the next questions. The test is voluntary. There are three reasons to be tested. (1) most women do not consider themselves at risk or are not aware of their partner's risky behaviors; (2) new medications are available to reduce the chance of an infected mother passing HIV to her baby; (3) most women do not know if they are infected with HIV until late in the disease. The following questions will help your health care provider determine other areas for counseling and evaluation.

Yes No Unsure 18. Have you or your sexual partners ever had a sexually transmitted disease (STD or VD) such as chlamydia, gonorrhea, syphilis, or herpes?

Yes No Unsure 19. Have you ever had a serious pelvic infection or pelvic inflammatory disease (PID)?

Yes No Unsure 20. Do you think any of your male sexual partners have ever had sex with other men?

Yes No Unsure 21. Have you or your sexual partners ever used IV street drugs?

Yes No Unsure 22. Have you had sex with two or more partners in the last twelve months?

Yes No Unsure 23. Do you think any of your sexual partners may have HIV or AIDS?

Yes No Unsure 24. 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.

25. Do you feel safe. . .
Yes No – in your personal relationship?
Yes No – within your home?
Yes No – in your own neighborhood?
Yes No – other (specify) _____

Yes No 26. Have you ever had your feelings repeatedly hurt, been repeatedly put down, or experienced other kinds of hurting?

If you're under 18, and you answer "yes" to the following questions, your care provider must report this information to Child Protective Services.

Yes No 27. 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 ☐ Stranger
☐ Partner ☐ Other (specify) _____

Yes No 28. Are you experiencing or have you ever experienced uncomfortable touching or forced sexual contact? If yes, by whom?
☐ Husband ☐ Family Member
☐ Ex-husband ☐ Stranger
☐ Partner ☐ Other (specify) _____