Oregon Medical Group Prenatal History Questionnaire

Name:___________________________________ Date of Birth:______________ Today's Date:_________________

Occupation:______________________________________ Hospital of Delivery: McKenzie Willamette Medical Center

Type of work: ____________________________________ Number of children at home:_______________________

Education: ______________________________________ Father of Baby:__________________________________

OB Provider :_____________________________________ Baby's Father Occupation: ________________________

Newborn's Provider: _______________________________ Baby's father phone #____________________________

Menstrual History

1st day of last menstrual period:____________________________ ☐ Unsure

Have you had an ultrasound for this pregnancy? Yes Where?____ No

Were you using birth control when you became pregnant? Yes No What type? ________________________

Did you do a home pregnancy test? Yes No Date of test:_____________________________________

Pre-pregnancy weight:________________

Symptoms since your last menstrual period: ☐ not having periods ☐ nausea ☐ vomiting

☐ fatigue ☐ irritability ☐ bloating ☐ tender breasts ☐ urinary frequency Other:________________________

Current Medications: please list all medications, vitamins, supplements, herbals, etc.

____

____

Current Allergies: please list all allergies to food, drugs, insects, etc.

____

____

Past Medical History: please check if you have had any of the following

☐ Abnormal Pap Smear	☐ Crohn's Disease	☐ High Blood Pressure	☐ Osteoarthritis
☐ Asthma	☐ Clotting disorder	☐ Hepatitis B	☐ Stomach Ulcer Disease
☐ Irregular heartbeat	☐ Colon Cancer	☐ Hepatitis C	☐ RH Sensitized
☐ Anemia	☐ Depression	☐ HIV/AIDS	☐ Rheumatoid Arthritis
☐ Anxiety	☐ DES Exposure	☐ Immunocompromised	☐ Seizure Disorder
☐ Autoimmune Disorder	☐ Diabetes – Type 1	☐ History of infertility	☐ Sleep Apnea
☐ Bleeding Disorder	☐ Diabetes – Type 2	☐ History of kidney infection	☐ Stroke
☐ Breast Disease	☐ Diabetes – Gestational	☐ Kidney Disease	☐ Thyroid Disorder
☐ Cancer	☐ Diverticulitis	☐ Kidney Failure	☐ Abnormal Uterus
☐ Breast Cancer	☐ Blood Clot	☐ Kidney Stone	☐ Recurrent UTI
☐ Cervical Cancer	☐ Genetic disorder	☐ Liver Disease	☐ Varicose Veins
☐ Ovarian Cancer	☐ GI Bleeding	☐ Lupus	☐ Von Willebrand Dis.
☐ Colon Cancer	☐ Heartburn	☐ Heart Attack	☐ Other (list)
☐ Other__________	☐ Heart Disease	☐ Migraine Headache	____________________
☐ Emphysema/COPD	☐ High Cholesterol	☐ MRSA	____________________

Past Surgical History: please list all surgeries with date

Procedure Date Procedure Date

______________________________ ______________________________

______________________________ ______________________________

______________________________ ______________________________

Any problems with anesthesia during past surgeries? ☐ Yes ☐ No

OB/GYN History: please check if you have had any of the following

☐ Sexually transmitted disease (STD), Type:________________________________

☐ Abnormal pap, Type:________________________________

☐ Breast problem or surgery, Type:________________________________

☐ Gynecological surgery, Type:________________________________

☐ Cold Knife Conization ☐ Colposcopy ☐ LEEP ☐ Endometrial Ablation

☐ Other Gynecological problem:

☐ Fibroids ☐ Painful periods ☐ Heavy/long periods ☐ Dysfunctional Uterine Bleeding

☐ Ovarian Cysts ☐ Ectopic Pregnancy ☐ Endometriosis ☐ Recurrent Yeast Infections

☐ Recurrent vaginal infections

☐ Cancer (location, date, status):________________________________

____

Past Pregnancy History – list each pregnancy, most recent first:

Birth Date	Weeks along at delivery	Pre Term labor	Delivery Type	Hrs in labor	Anesthesia	Hospital	Sex	Birth Weight	Name

Family History:

☐ Unknown

☐ Heart Disease Relative(s)____ Age(s) ___________________________

☐ Breast Cancer Relative(s)____ Age(s) ___________________________

☐ Ovarian Cancer Relative(s)____ Age(s) ___________________________

Genetic History:

Do you or any family member have any of the following, if unsure the answer is likely NO:

Thalassemia ☐ Yes ☐ No Self or family member? ___________________________

Neural Tube Defect ☐ Yes ☐ No Self or family member? ___________________________

Down Syndrome ☐ Yes ☐ No Self or family member? ___________________________

Tay-Sachs ☐ Yes ☐ No Self or family member? ___________________________

Sickle Cell Disease/Trait ☐ Yes ☐ No Self or family member? ___________________________

Hemophilia ☐ Yes ☐ No Self or family member? ___________________________

Muscular Dystrophy ☐ Yes ☐ No Self or family member? ___________________________

Cystic Fibrosis ☐ Yes ☐ No Self or family member? ___________________________

Huntington's Disease ☐ Yes ☐ No Self or family member? ___________________________

Mental Retardation ☐ Yes ☐ No Self or family member? ___________________________

Fragile X ☐ Yes ☐ No Self or family member? ___________________________

Other Genetic Chromosomal ☐ Yes ☐ No Self or family member? ___________________________

Child with other birth defect ☐ Yes ☐ No Self or family member? ___________________________

More than 3 spontaneous miscarriages ☐ Yes ☐ No

History of stillbirth ☐ Yes ☐ No

Social History and Risk Factors:

Alcohol Use ☐ Yes ☐ No Number drinks/day _____________________________

Caffeine Use ☐ Yes ☐ No Number drinks/day _____________________________

Marijuana Use ☐ Yes ☐ No How often? _____________________________

Do you exercise? ☐ Yes ☐ No How often? _____________________________

Sun exposure? ☐ Yes ☐ No

Risk of exposure to HIV? ☐ Yes ☐ No Comments ____

Risk of exposure to Hepatitis? ☐ Yes ☐ No Comments____

Risk of STD's? ☐ Yes ☐ No Comments____

Risk of exposure to HIV? ☐ Yes ☐ No Comments____

Do you smoke? ☐ Yes ☐ No Packs/day ___________ How long? __________________

If you used to smoke and have stopped, when did you stop?____

Do you use other tobacco products including e-cigarettes? ☐ Yes ☐ No Comments______________________

Are you exposed to smoke at home or work? ☐ Yes ☐ No Comments___________________________________

Are you at risk of falling? ☐ Yes ☐ No Comments____

Seat Belt use? ☐ Yes ☐ No Comments____

Helmet use on bikes? ☐ Yes ☐ No Comments____

Sexual history: (check all that apply)

☐ Currently monogamous ☐ Multiple partners currently ☐ Multiple partners in the past

☐ Female sex partner ☐ HIV positive partner

High risk sexual behavior: ☐ Sex for money ☐ Sex for drugs

Drug use: (check all that apply)

☐ Never ☐ Former ☐ Current ☐ What drugs are you using?_______________________________________

Blood transfusion history: (check all that apply)

☐ Religious objection to receiving ☐ No history of blood transfusion

☐ Yes When? ☐ Before 1987 ☐ 1987 – 1988 ☐ 1988 – 2001 ☐ After 2001

☐ Prior to HIV diagnosis ☐ After HIV diagnosis

Infection history:

High risk for Hepatitis B	☐ Yes	☐ No	Comments_________________________
Immunized against Hep B	☐ Yes	☐ No	Comments_________________________
Exposure to TB	☐ Yes	☐ No	Comments_________________________
History of genital herpes	☐ Yes	☐ No	Comments_________________________
Sexual partner with history of genital herpes	☐ Yes	☐ No	Comments_________________________
Exposure to xrays:	☐ Yes	☐ No	Comments_________________________
Medication since last menstrual period:	☐ Yes	☐ No	Comments_________________________
Chemical/other exposure	☐ Yes	☐ No	Comments_________________________
Rash, viral or febrile illness since last menstrual period:	☐ Yes	☐ No	Comments_________________________
Exposure to cat litter	☐ Yes	☐ No	Comments_________________________
Chicken pox immune status	☐ history of disease	☐ history of vaccine	
History of parvovirus (Fifth Disease)	☐ Yes	☐ No	Comments_________________________
Occupational exposure to children	☐ Yes	☐ No	Comments_________________________

Comments: For office use

Thank you for taking the time to complete this Prenatal Health History Form!

This information will be helpful as we care for you during your pregnancy.

Please remember to bring the form to your Nurse Educator Visit.