New Pregnancy Questionnaire

Today's Date_____/_____/_____

Patient's Full Name: _____Birth Date: _____/_____/_____
Allergies: (food, medication, other) _____ [ ] none

Which provider do you want to see? Dr Cain Jessica George CNM Jessie Costa CNM
Where would you like to deliver? (circle one)
Aultman Orrville Hospital (George, Costa, Cain)
Aultman Canton (Dr Cain only)
Mercy Medical Center (Dr Cain only)
Mt Eaton Care Center (serving the plain community only, George, Costa, Cain)

First Day of Last Menstrual Period: _____Are You Sure of the Date? Y N
Was it a Normal Period? Y N
Did you take a home pregnancy test? Y N

How many times have you been pregnant? _____
How many times have you given birth? _____
Have you had any babies born more than 3 weeks early? Y N
Pre-pregnant weight _____ Height_____

At what age did you start your first period? _____
How far apart are you periods? _____
How long do they last? _____
Have you ever used birth control? Y N
If yes what type _____ and when_____

Your Medical History

Have You Ever Had?

Low iron in pregnancy	Y	N
Miscarriage / Stillbirth	Y	N
Diabetes of Pregnancy	Y	N
Bleeding - during pregnancy or too much after birth	Y	N
Too Much Vomiting	Y	N
Baby Not Growing Enough	Y	N
Baby Blues / Postpartum Depression	Y	N
High Blood Pressure in Pregnancy	Y	N
Preterm Labor or Birth	Y	N
Negative Blood Type, Had to get Rhogam Shot	Y	N
Other Pregnancy Complications	Y	N
Abnormal Pap Smear	Y	N
Chlamydia / Gonorrhea / Herpes / Syphilis	Y	N
Trichomonas (“Trich”) / HPV (genital warts)	Y	N
Other Infections or Vaccinations (Rubella, Chicken Pox, Hepatitis)	Y	N

Patient's Full Name: _____Birth Date: _____/_____/_____

Your History since Your Last Menstrual Period

Have You Had Any?		
Vaginal Bleeding	Y	N
Abdominal (Stomach) Pain	Y	N
Headache / Dizziness	Y	N
Change in Vision	Y	N
Extreme vomiting	Y	N

Your History Since Your Last Menstrual Period (continued)

Have You Had Any?		
Fever	Y	N
Rash with an Illness	Y	N
Physical Injury or Surgery	Y	N

Have You Been Exposed To?

HIV / CMV / Herpes / Syphilis	Y	N
Rubella (German measles) / Chicken Pox	Y	N
Other Infections (TB, Hepatitis, etc)	Y	N
Toxic Chemicals	Y	N
Radiation (X-Rays)	Y	N

Have any babies been born with:

Cerebral Palsy	N	Y – Me	Y – My Family	Y – Husband's family
Cleft Lip / Palate	N	Y – Me	Y – My Family	Y – Husband's family
Birth Defects	N	Y – Me	Y – My Family	Y – Husband's family
Heart Defects	N	Y – Me	Y – My Family	Y – Husband's family
Cystic Fibrosis	N	Y – Me	Y – My Family	Y – Husband's family
Down Syndrome	N	Y – Me	Y – My Family	Y – Husband's family
Hemophilia (Bleeders)	N	Y – Me	Y – My Family	Y – Husband's family
Huntington's Chorea	N	Y – Me	Y – My Family	Y – Husband's family
Mental Retardation	N	Y – Me	Y – My Family	Y – Husband's family
Muscular Dystrophy	N	Y – Me	Y – My Family	Y – Husband's family
Spina Bifida	N	Y – Me	Y – My Family	Y – Husband's family
Sickle Cell Disease/Trait	N	Y – Me	Y – My Family	Y – Husband's family
Tay - Sachs disease	N	Y – Me	Y – My Family	Y – Husband's family
Fragile X	N	Y – Me	Y – My Family	Y – Husband's family
Thalassemia A or B	N	Y – Me	Y – My Family	Y – Husband's family
Other genetic condition	N	Y – Me	Y – My Family	Y – Husband's family

Please list: _____

Please list any questions and concerns you have at this time: _____