Georgia Perinatal Consultants

PATIENT HISTORY AND SCREENING QUESTIONNAIRE

AFFIX PATIENT LABELS OVER THIS BOX

BAR CODE MUST FALL BETWEEN THESE LINES

Name _____
(First Name) (Middle) (Last Name) (Preferred Name)

First day of last menstrual period: _____ Estimated Due Date: _____ Referring OB/MD: _____
If pregnancy resulted from fertility treatments, what method? _____ If Donor Egg pregnancy, age of donor:_____
What will be your age on your due date? _____ What is your Weight? _____ Height? _____
Please list total number of previous pregnancies: _____
Number of preterm deliveries (less than 37 weeks: _____ Number of miscarriages: _____
Number of abortions: _____ Number of living children: _____

Have you had 3 or more spontaneous losses OR a stillbirth? ☐ Yes ☐ No If Yes, please explain: _____

Do you have:
a. High blood pressure ☐ Yes ☐ No
b. Asthma ☐ Yes ☐ No
c. Diabetes ☐ Yes ☐ No
d. Epilepsy ☐ Yes ☐ No
e. Lupus ☐ Yes ☐ No
f. Thyroid disease ☐ Yes ☐ No
g. History of blood clots ☐ Yes ☐ No
h. Other _____

If yes to any of the above, please explain: _____

Age **40 and older**: Have you had a screening mammogram in the last 12 months? ☐ Yes ☐ No
List any surgeries (including C-section) you have had: _____

Have you ever had a LEEP procedure? ☐ Yes ☐ No

Do you drink alcoholic beverages? ☐ Yes ☐ No How many drinks per week? _____

Do you smoke cigarettes: ☐ Yes ☐ No How many packs per day? _____

Have you used any recreational drugs during this pregnancy? ☐ Yes ☐ No

Have you had an X-ray examination during this pregnancy? ☐ Yes ☐ No If Yes, explain: _____
Please list all MEDICATIONS taken during pregnancy including dosage (excluding iron and vitamins):
_____
List any known ALLERGIES you have to drugs, food, iodine or latex (or write NONE- do not leave blank):
_____

Please describe your exercise habits: _____

Are you, the baby's father, or anyone in either of your families affected by:

a. Spina bifida/open spine or anencephaly ☐ Yes ☐ No
b. Hemophilia ☐ Yes ☐ No
c. Muscular dystrophy ☐ Yes ☐ No
d. Down Syndrome ☐ Yes ☐ No
e. Mental Retardation ☐ Yes ☐ No
f. Heart Defect ☐ Yes ☐ No
g. Hydrocephalus ☐ Yes ☐ No
h. PKU ☐ Yes ☐ No
i. Cystic Fibrosis ☐ Yes ☐ No
j. Tay-Sachs Disease ☐ Yes ☐ No
k. Cleft Lip or Palate ☐ Yes ☐ No
l. Clubbed Foot ☐ Yes ☐ No

Have you, the baby's father or any relative ever had any birth defect, chromosomal abnormality or inherited health problem not listed above? ☐ Yes ☐ No If yes, please describe: _____

Are you or the baby's father of **Jewish, French Canadian or Cajun** ancestry? □ Yes □ No
If yes, have either of you been screened for Tay-Sachs disease? □ Yes □ No
Are you or the baby's father **African-American or Latino**? □ Yes □ No
If yes, have either of you been screened for sickle cell carrier status? □ Yes □ No
Do you or the baby's father have an **Italian, Greek, Mediterranean, Southern Chinese, Taiwanese or Philippine** background? □ Yes □ No
If yes, have either of you been screened for Thalassemia? □ Yes □ No

If yes to any of the above, please give results: _____

Are you and the baby's father related in any way (i.e., cousins)? □ Yes □ No

Please explain any major concerns you have about your pregnancy or family history which are not mentioned above:
_____

Patient Signature: _____ Reviewer's Signature: _____

Interpreter Signature: _____ Date: _____ Time: _____ A.M./P.M.
□ Live Interpreter □ Phone interpreter ID# _____