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	e. Lupus	☐ Yes	☐ No
b. Asthma	☐ Yes	☐ No	f. Thyroid disease	☐ Yes	☐ No
c. Diabetes	☐ Yes	☐ No	g. History of blood clots	☐ Yes	☐ No
d. Epilepsy	☐ 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	g. Hydrocephalus	☐ Yes	☐ No
b. Hemophilia	☐ Yes	☐ No	h. PKU	☐ Yes	☐ No
c. Muscular dystrophy	☐ Yes	☐ No	i. Cystic Fibrosis	☐ Yes	☐ No
d. Down Syndrome	☐ Yes	☐ No	j. Tay-Sachs Disease	☐ Yes	☐ No
e. Mental Retardation	☐ Yes	☐ No	k. Cleft Lip or Palate	☐ Yes	☐ No
f. Heart Defect	☐ 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# _____