



PATIENT HISTORY QUESTIONNAIRE - CONFIRMATION VISIT

Our goal is for you to be as healthy as possible. This is a detailed history form to get the big picture about your current health and your individual needs. Please print, complete and email this questionnaire back prior to your first visit.

PATIENT INFORMATION

Patient name (last, first, M.I): _____ Preferred Name: _____
Gender Identity: Female Male Nonbinary Other: (specify) _____ Date of birth: _____ Age: _____
Sex at birth: Female Male Intersex Pronouns: she/her he/him they/them other: _____
Ethnic group/race: _____
Are you: Single In a relationship Married Divorced Widowed Other: _____
Name of partner _____ Age _____ Pronouns: she/her he/him they/them other: _____
Is this the biological father of the baby? Yes No Unknown Ethnic group/race: _____
Occupation _____
Has your partner ever had genital herpes, HIV, viral hepatitis or other conditions that could affect this pregnancy? Yes No

YOUR BODY BEFORE THIS PREGNANCY

At what age did you get your first period? _____
Is this a desired pregnancy? Yes No If no, would you like to discuss options for termination or adoption? Yes _____ No
Birth control method in past year: None Pills Condoms Natural family planning IUD Ring Patch DepoProvera injection Implanon/Nexplanon Other When did you stop using this method? _____
Have you used emergency contraception in the past year? Yes No If so, how many times? _____

First day of your last period: _____ Exact (+/- one day) Approximate Unknown
• Was your period normal in number of days and flow? Normal Abnormal
• Were your periods every 25-32 days? Yes No - describe: _____
Date of conception, if known: _____
Did you have fertility treatment for this pregnancy? Yes No
• If yes, please explain: _____
• IUI (date) _____ Embryo transfer date _____
• Are you a surrogate or gestational carrier for this pregnancy? Yes No
Did you have 3 normal natural menstrual cycles in a row prior to conceiving? Yes No
Do you have any history of breast surgeries? (Breast implants, breast reduction) Yes No
Were you breastfeeding during your last 3 menstrual cycles? Yes No
• If yes, are you breastfeeding now? Yes No If no, date stopped _____
Are you planning to breastfeed after this pregnancy? Yes No Undecided
Have you had breastfeeding problems in the past? Yes No
• If yes, please explain _____

CURRENT SYMPTOMS List any concerns or problems that you have with your current pregnancy.

Breast changes _____
 Nausea and vomiting _____
 Vaginal symptoms (bleeding, spotting, abnormal discharge) _____
 Abdominal pain or cramping _____
 Change in bowel habits (constipation, diarrhea) _____
 Urinary symptoms (frequency, burning, pain with urination) _____
 Fatigue _____
 Other _____

ALLERGIES

Do you have any allergies to any medications or foods? Yes No If yes, please list and describe the reaction. ie: Penicillins - hives

Allergy/Reaction	Allergy/Reaction

CURRENT MEDICATIONS

Include prescribed, over-the-counter drugs, folic acid or vitamins, herbal remedies or supplements, inhalers

Name of medication	Strength/dose	Frequency taken	Reason for taking

PAST OBSTETRIC HISTORY

Total number of pregnancies which are listed below _____ Living children _____ Full-term births _____ Premature births _____

Multiple births _____ Miscarriages _____ Terminations _____ Tubal pregnancies _____ Molar pregnancies _____

Previous Pregnancies (Include miscarriages, terminations, and/or ectopic/tubal pregnancies)										
Date	How many weeks did your pregnancy last?	How long was your labor? (hours)	Type of birth (vaginal, c/s, forceps, vacuum)	Sex M/F/ Other Baby Name	How much did your baby weigh?	Did you have preterm labor?	Did you or your baby experience any problems during labor or birth?	Were there any other pregnancy or procedural complications?	Did you use anesthesia? If so, what type? (eg: nitrous, narcotics, epidural, spinal)	Place of birth/ CNM/ OB

<p>Have you had problems in your prior pregnancies not listed above?</p> <p><input type="checkbox"/> gestational diabetes <input type="checkbox"/> pelvic floor problems or incontinence</p> <p><input type="checkbox"/> high blood pressure <input type="checkbox"/> pelvic pain</p> <p><input type="checkbox"/> pre-eclampsia <input type="checkbox"/> 3rd or 4th degree laceration</p> <p><input type="checkbox"/> postpartum hemorrhage or excessive bleeding after birth <input type="checkbox"/> other</p>	<p>Please explain:</p>
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PAST GYNECOLOGIC HISTORY

When was your last pap test? _____	Was it normal? <input type="checkbox"/> Yes <input type="checkbox"/> No
Have you ever had an abnormal pap test?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Have you completed vaccination for Hepatitis B?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Have you completed vaccination for HPV (Gardasil/Cervarix/other)?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Who do you have sex with? <input type="checkbox"/> Male partner <input type="checkbox"/> Female partner <input type="checkbox"/> Transgender partner <input type="checkbox"/> Other: _____	
What types of sex do you have? <input type="checkbox"/> Genital (penis in the vagina) <input type="checkbox"/> Anal (penis in the anus) <input type="checkbox"/> Oral (mouth on penis, vagina or anus)	
<input type="checkbox"/> Other (digital/finger or toys in vagina or anus)	
Do you use condoms? <input type="checkbox"/> Yes <input type="checkbox"/> No	
How many partners do you currently have? _____	How many partners in the past 6 months? _____
Have you ever had any of the following infections?	
<input type="checkbox"/> Chlamydia <input type="checkbox"/> Genital herpes <input type="checkbox"/> Genital warts <input type="checkbox"/> Gonorrhea <input type="checkbox"/> Syphilis <input type="checkbox"/> HIV/AIDS <input type="checkbox"/> HPV <input type="checkbox"/> Pelvic inflammatory disease (PID)	
Have you had past infertility workups or treatment? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please describe: _____	
Do you have a history of fibroids or abnormally shaped uterus? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please describe: _____	
Have you ever had a gynecological surgical procedure such as:	
<input type="checkbox"/> Ectopic pregnancy or surgery on your fallopian tube	<input type="checkbox"/> Dilation/curettage (D&C)
<input type="checkbox"/> LEEP procedure	<input type="checkbox"/> Hysteroscopy
<input type="checkbox"/> Cervical conization	<input type="checkbox"/> Cerclage
<input type="checkbox"/> Cryosurgery (freezing) of the cervix	<input type="checkbox"/> Other/Date: _____
<input type="checkbox"/> Laser treatment	<input type="checkbox"/> None
Include other dates and details on above or any other gynecologic issues (incontinence, vulvodynia, vulva vestibulitis, other)	

PAST MEDICAL HISTORY

<input type="checkbox"/> Hypertension (high blood pressure)	<input type="checkbox"/> Heart disease, mitral valve prolapse or rheumatic fever	
<input type="checkbox"/> Autoimmune disease (eg: lupus, rheumatoid arthritis, other)	<input type="checkbox"/> Kidney disease, kidney infections	
<input type="checkbox"/> Epilepsy or seizures <input type="checkbox"/> Migraine headaches	<input type="checkbox"/> Frequent UTIs or other urinary tract problems	
<input type="checkbox"/> Stroke <input type="checkbox"/> Other neurologic problems	<input type="checkbox"/> Depression, anxiety, ADHD, other psychiatric conditions	
<input type="checkbox"/> Hepatitis B or C, liver disease, yellow jaundice	<input type="checkbox"/> Eating disorder (anorexia, bulimia, other)	
<input type="checkbox"/> Thyroid problems or take thyroid medication	<input type="checkbox"/> Major accidents or suffered trauma	
<input type="checkbox"/> Other endocrine problems	<input type="checkbox"/> Blood clots in your veins, deep vein thrombosis, inflammation of the veins, phlebitis, pulmonary embolism	
<input type="checkbox"/> History blood transfusions <input type="checkbox"/> Anemia	<input type="checkbox"/> Breast problems or surgeries not mentioned previously	
<input type="checkbox"/> Excessive bleeding after surgery or dental work	<input type="checkbox"/> Diabetes (high blood sugar)	
<input type="checkbox"/> Asthma or other pulmonary issues	<input type="checkbox"/> Vitamin D deficiency	
Have you had chicken pox (varicella)? <input type="checkbox"/> Disease <input type="checkbox"/> Vaccine	<input type="checkbox"/> None	
If yes, please explain: _____		
Do you have, or have you ever had, any of the following?		
<input type="checkbox"/> Pernicious anemia	<input type="checkbox"/> Celiac disease	<input type="checkbox"/> MTHFR (methyltetrahydrofolate reductase) mutation
<input type="checkbox"/> Weight loss surgery	<input type="checkbox"/> Crohn's disease	<input type="checkbox"/> Family history of MTHFR mutation
<input type="checkbox"/> Irritable bowel syndrome	<input type="checkbox"/> Ulcerative colitis	<input type="checkbox"/> Ulcers, acid reflux, other GI issues <input type="checkbox"/> None
If yes, please explain: _____		

Surgical procedures, other than obstetrical or gynecologic, give reason and date if yes: Yes No

- If yes, please explain: _____

A hospital stay for a non-surgical reason other than normal birth: Yes No

- If yes, please explain: _____

Have you had any complications from anesthesia: Yes No

- If yes, please explain: _____

Have you ever been exposed to tuberculosis or COVID: Yes No

- If yes, please explain: _____

Have you ever had any other infectious disease: Yes No

- If yes, please explain: _____

GENETICS AND FAMILY HISTORY

Family History – Please list the family member who has had one of the conditions below and their age at diagnosis

- Asthma, blood clots (DVT), diabetes, heart disease, high blood pressure, thyroid disease
- Cancer: Breast, Colon, Ovarian, Pancreatic, Skin, Stomach, Uterine (not cervical cancer)
- Psychiatric conditions (anxiety, depression, bipolar, other)

Family Member	Condition/Age at Diagnosis

Genetic History - Please indicate if any of these conditions apply to your family or anyone in the father of the baby's family

NAME OF CONDITION	YES	NO	RELATIONSHIP OF AFFECTED PERSON TO YOU
Neural tube defect (open spine, spina bifida, anencephaly)			
Congenital heart disease or defect			
Down Syndrome (Trisomy 21)			
Hemophilia or other blood clotting disorders			
Cystic Fibrosis			
Any genetic muscle disorders like Muscular Dystrophy, Spinal Muscular Atrophy (SMA)			
Intellectual or mental disability or autism			
Fragile X syndrome			
Bone/skeletal defects			
Polycystic kidney disease			
Cleft lip/palate			
Other familial, genetic or chromosomal disorders			

Are you or the biological father of the baby of Ashkenazi Jewish ancestry? Yes No

• If yes, have you been screened for: Tay-Sachs disease Canavan disease Familial dysautonomia

• If yes, who was screened and what were the results? _____

Are you or the biological father of the baby of African or African American ancestry? Yes No

• If yes, have either of you been screened for sickle cell trait or disease?

• If yes, who was screened and what were the results? _____

Are you or the biological father of the baby of Mediterranean or Asian ancestry? Yes No

• If yes, have either of you been screened for: Thalassemia Sickle cell disease or trait

• If yes, who was screened and what were the results? _____

Do you or the biological father of the baby have:

• Insulin dependent diabetes, phenylketonuria (PKU), congenital adrenal hyperplasia (CAH) or any other metabolic disorder

• A prior child with a birth defect or medical condition needing surgery not listed above

• Three or more miscarriages or prior stillbirth

• A child that died shortly after birth or during childhood

If yes, please explain: _____

Do you have a mother or sister who had pre-eclampsia? Yes No

Were you born at a low birth weight (less than 6 pounds)? Yes No

SOCIAL HISTORY

What is your profession/occupation? _____

What are your hobbies/activities? _____

How do you like to joyfully move your body? How many times per month? _____

Do you eat at least 5 servings of fruits/veggies per day? Yes No What is your favorite vegetable? _____

Do you avoid certain foods groups (gluten, red meat, etc) _____

Do you drink caffeine (soda, tea, coffee)? Yes No If yes, type and number of cups per day _____

Do you have any religious or cultural preferences that may impact your care? Yes No

If yes, please describe _____

Would you agree to have a blood transfusion in order to save your life or the life of your baby? Yes No

Who do you currently live with? _____

Do you have cats at home? Yes No If yes, do you change the litterbox? Yes No

Do you have lead based paint at home (usually in homes built before 1978)? Yes No Unsure

Does anyone in your home smoke? Yes No

Do you wear your seatbelt every time you drive or ride in a vehicle? Yes No

Have you traveled outside of the country in the past 6 months? If yes, where? _____

Have you experienced a death or other trauma that may affect this pregnancy? Yes No

• Comments: _____

Are there other medical or personal concerns that we have not asked you about which you feel might be of importance to this pregnancy?

Yes No If yes, please explain: _____