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:______________
Date of first positive home pregnancy test: ____________
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

Have you had problems in your prior pregnancies not listed above?	Please explain:
☐ gestational diabetes ☐ pelvic floor problems or incontinence ☐ high blood pressure ☐ pelvic pain ☐ pre-eclampsia ☐ 3rd or 4th degree laceration ☐ postpartum hemorrhage or excessive bleeding after birth ☐ other	

PAST GYNECOLOGIC HISTORY

When was your last pap test? ___________________________ Was it normal? ☐ Yes ☐ No
Have you ever had an abnormal pap test? ☐ Yes ☐ No
Have you completed vaccination for Hepatitis B? ☐ Yes ☐ No
Have you completed vaccination for HPV (Gardasil/Cervarix/other)? ☐ Yes ☐ No

Who do you have sex with? ☐ Male partner ☐ Female partner ☐ Transgender partner ☐ Other:_______________________________
What types of sex do you have? ☐ Genital (penis in the vagina) ☐ Anal (penis in the anus) ☐ Oral (mouth on penis, vagina or anus) ☐ Other (digital/finger or toys in vagina or anus)
Do you use condoms? ☐ Yes ☐ 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?
☐ Chlamydia ☐ Genital herpes ☐ Genital warts ☐ Gonorrhea ☐ Syphilis ☐ HIV/AIDS ☐ HPV ☐ Pelvic inflammatory disease (PID)

Have you had past infertility workups or treatment? ☐ Yes ☐ No If yes, please describe: ___________________________________
Do you have a history of fibroids or abnormally shaped uterus? ☐ Yes ☐ No If yes, please describe: _________________________

Have you ever had a gynecological surgical procedure such as:

☐ Ectopic pregnancy or surgery on your fallopian tube	☐ Dilation/curettage (D&C)
☐ LEEP procedure	☐ Hysteroscopy
☐ Cervical conization	☐ Cerclage
☐ Cryosurgery (freezing) of the cervix	☐ Other/Date: _____________________________________
☐ Laser treatment	☐ None

Include other dates and details on above or any other gynecologic issues (incontinence, vulvodynia, vulva vestibulitis, other)

PAST MEDICAL HISTORY

☐ Hypertension (high blood pressure)	☐ Heart disease, mitral valve prolapse or rheumatic fever
☐ Autoimmune disease (eg: lupus, rheumatoid arthritis, other)	☐ Kidney disease, kidney infections
☐ Epilepsy or seizures ☐ Migraine headaches	☐ Frequent UTIs or other urinary tract problems
☐ Stroke ☐ Other neurologic problems	☐ Depression, anxiety, ADHD, other psychiatric conditions
☐ Hepatitis B or C, liver disease, yellow jaundice	☐ Eating disorder (anorexia, bulimia, other)
☐ Thyroid problems or take thyroid medication	☐ Major accidents or suffered trauma
☐ Other endocrine problems	☐ Blood clots in your veins, deep vein thrombosis, inflammation of the veins, phlebitis, pulmonary embolism
☐ History blood transfusions ☐ Anemia	
☐ Excessive bleeding after surgery or dental work	☐ Breast problems or surgeries not mentioned previously
☐ Asthma or other pulmonary issues	☐ Diabetes (high blood sugar)
Have you had chicken pox (varicella)? ☐ Disease ☐ Vaccine	☐ Vitamin D deficiency
Are you vaccinated for Covid-19? Yes No Date of vaccination(s)______________(Please bring your vaccination card to your visit)	☐ None

If yes, please explain:

Do you have, or have you ever had, any of the following?

☐ Pernicious anemia ☐ Celiac disease ☐ MTHFR (methyltetrahydrofolate reductase) mutation
☐ Weight loss surgery ☐ Crohn's disease ☐ Family history of MTHFR mutation
☐ Irritable bowel syndrome ☐ Ulcerative colitis ☐ Ulcers, acid reflux, other GI issues ☐ 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 a 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: ____