Family Health Centers
of Southern Indiana

PREGNANCY QUESTIONNAIRE

PLEASE ANSWER ALL OF THE QUESTIONS; if it is not applicable, please respond with "0" or "N/A"

Patient's Name: _____ Today's Date: _____
DOB _____ Age _____ SSN _____
Full Address_____
Mailing Address if different than above_____
Race (check all that apply) White____ Black____ Asian____ Indian___ Hispanic___ other__
What is your primary language? _____ How tall are you? _____
Marital Status: Single_____ Married_____ Widowed____ Separated_____ Divorced_____
First day of your last menstrual period: month _____day _____year _____
Are you sure about that date? Yes_____ No_____ Weight before being pregnant _____
Do you **smoke**? _____ If yes, how much daily? _____
Do you **drink alcohol**? _____ If yes, how often? _____
Do you **use illegal drugs**? _____ If yes, how often? _____
Do you work outside the home? _____ Where? _____
Your phone number/s: Home (____) _____ Cell (____) _____
Work (____) _____ Other: (____) _____
Have you applied for Medicaid /Hoosier Healthwise? Yes_____ No_____
If not, why? _____
Are you planning to apply? _____ Do you have private insurance? _____
OR are you insured through work and eligible for pregnancy coverage?
_____
If you are over 14 weeks pregnant today and you had not received any prenatal care before now, please tell us, why? _____
Are you a U.S. **citizen**? Yes_____ No_____ **If you are not a U.S. Citizen**, what is your legal migratory status? _____
In what hospital do you plan to deliver? _____
Are you planning to breastfeed? _____ Who will be your baby's pediatrician? _____
Name of your husband or domestic partner: _____ Age: _____
His/Her phone number/s: Home (_____) _____ Cell (_____) _____
Work (_____) _____ Other: (_____) _____
Name of the father of baby (if different than husband or partner): _____ Age: ___
In case of an emergency, who can we contact and their phone number/s: _____
_____
List any allergies to medications or foods: _____
Do you have a latex allergy? Yes____ No____ If you have had a reaction to any allergy, what and how was it? _____

Patient Name _____
DOB _____

Are you currently taking prenatal vitamins? Yes _____ No _____
Are you currently taking any other medications? Yes _____ No _____ if yes, please list all of them: _____ _____.
Have you had to go to the ER since this pregnancy started? _____ Date: _____
Where?_____
How many pregnancies have you had? Include miscarriages, abortions, **and this one**: _____
If this is not your first pregnancy, how many children have you delivered? _____
How many abortions, if any? _____ How many miscarriages, if any? _____
How many living children? _____
Were you on birth control at the time of conception? Yes_____ No_____
if yes, what you were on? _____
Did you take a home pregnancy test? Yes__ No__; If no, where and when do you have one done?
_____

Please list all of your pregnancies in order, from your older child to the more recent pregnancy. PLEASE include any miscarriages and abortions:

Child	Born: Month/Year	Sex	First Name	Birth weight	Hours in Labor	How many Weeks	Vaginal, or C-Section, or Induction	Anesthesia	Any problems for baby or mom?	Who was your doctor or hospital/ state?
1	/									
2	/									
3	/									
4	/									
5	/									
6	/									

MEDICAL HISTORY: Does anyone in your family have any of these diseases/disorders? If any, please list who it is, like: mother, father, paternal grandfather, maternal grandmother, sister, maternal aunt, etc. Please also include YOURSELF, the father of the baby (FOB) and your children if applicable.

Health Problems:	Varicose veins	Twins	Hypertension	Diabetes	Cancer	Migraines	Strokes	Mental Illness	Obesity	Gastrointestinal problems, or ulcers
Who has/had it?										

Health Problems:	Heart disease	Kidney disease	Liver Disease	Hepatitis	Lungs disease	Thyroid dysfunction	Tuberculosis	Pertussis	Asthma	Arthritis	Anemia
Who has/had it?											

Health Problems:	Pregnancy Diabetes	Drug Abuse	Blood transfusions	Breast disorders	Miscarriages	Bleeding disorder	Epilepsy	Other	Other
Who has/had it?									

Patient Name _____
DOB _____

Have you had a history of trauma or domestic violence? Yes____ No_____ If yes, please explain:

What is your blood type (if known)? _____ are you **Rh negative**? Yes_____ No_____
Have you ever been diagnosed with depression or postpartum depression? Yes_____ No_____
Do you have cats in home? Yes_____ No_____ Have you ever had surgery or been hospitalized? Yes _____ No _____ If yes, please list reason and dates:
1_____ 3._____

2_____ 4. _____

Have you had these symptoms since your last menstrual period? Check with an X inside the boxes.

Headaches	Fever	Abdominal pain	Vaginal discharge	Swelling	Viral exposure	X-rays exposure
Nausea	Vomiting	Urinary complaints	Vaginal bleeding	Breast tenderness	Drugs exposure	Other:

When was your last pap smear (if any)? _____ was the result normal or abnormal?
Where did you have it done? _____
Do you have a history of abnormal pap smears? If yes, explain: _____
_____
Were you ever told your uterus was tilted or shaped different? If yes, explain: _____
_____
Have you ever been diagnosed with herpes? Yes___ No___ If yes, what type? _____
Does your current sexual partner or husband have a history of genital herpes? Yes_____ No_____
How many sexual partners have you had? _____

Genetic screening involves your family as well as your husband's / FOB family. If applicable, indicate who has these disorders/birth defects

Health Problems:	Neural tube defect: meningomyelocele, spina bifida, or anencephaly	Down Syndrome	Sickle cell disease or trait	Hemophilia or other blood disorders	Muscular dystrophy	Cystic Fibrosis	Autism	Genetic or chromosomal disorders
Who has/had it?								

Patient Name _____
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Do you have a history of sexually transmitted disease (STD)? Please mark an X inside the corresponding boxes if you do.

HIV	Chlamydia	HPV
Syphilis	Hepatitis Type B	Hepatitis Type C
Gonorrhea	Other problem? Please explain:	

Is there any other relevant family history that you want to tell us about? If yes, please explain:

_____

_____

_____

This section for office use only.

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LMP:	CLARK		FLOYD
EDD:	Records requested?	Yes	No
32 wks.	Continuing care?	Yes	No
Appt. date:	Weeks:		

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