

PRENATAL HISTORY QUESTIONNAIRE

Having a healthy baby is a special event. Once a baby is born, families take certain precautions to ensure the baby's health and safety. The unborn child deserves similar care.

The following questions will help in the care of your pregnancy. Please answer these questions as well as you can. If you need help answering the questions, please ask your health care provider. The first questions relate to you. The next set of questions will be about you, your baby's father, and both your families. When thinking about your families, please include your child (or unborn baby), mother, father, sisters, brothers, grandparents, aunts, uncles, nieces, nephews, or cousins.

- Yes No 1. Will you be 35 years or older when the baby is due? Age when due: _____ .
- Yes No 2. Are you and the baby's father related to each other (i.e. cousins)?
- Yes No 3. Have you had three or more pregnancies that ended in miscarriage?
- Yes No 4. Have you delivered a premature baby (before 37 weeks)?
- Yes No 5. Have you or the baby's father had a stillborn baby, a baby who died around the time of delivery, or a baby who was small for gestational age?
- Yes No 6. Do either you or the baby's father have a birth defect or genetic condition such as a baby born with an open spine (spina bifida), a heart defect, or Down Syndrome?
- Yes No 7. Does anyone in your family or anyone in the baby's father's family have a birth defect or condition that has been diagnosed as genetic or inherited, such as open spine (spina bifida), a heart defect, or Down Syndrome?
- Yes No 8. Do you or anyone in your family or anyone in your baby's father's family have a history of stroke, deep vein thrombosis, or other blood clotting disorder?
- Yes No 9. Where your ancestors came from may sometimes give us important information about the health of your baby. Are you or the baby's father from any of the following ethnic/racial groups: Jewish, Black, Asian, Mediterranean (Greek, Italian)?
- Yes No 10. Have you or the baby's father ever been screened to see if either of you are carriers of the gene for any of the following: Tay-Sachs, Sickle Cell, Thalassemia, or Cystic Fibrosis?
- Yes No 11. Do you think you are at increased risk of having a baby with a birth defect or genetic disorder?
 If yes, which defect or disorder? _____
 Why do you think you are at increased risk? _____
- Yes No 12. At any time during the first two months of your pregnancy, have you had a rash or a fever of 103 F or greater?

Sometimes, the unborn baby can be exposed to outside factors that can cause birth defects. The next 8 questions will give us important information about possible exposure to the baby.

- Yes No 13. Have you traveled outside the country in the last 2 months? Where? _____
- Yes No 14. Have you had any x-rays during this pregnancy?
- Yes No 15. Have you had any alcohol during this pregnancy?
16. Prior to your pregnancy, how often did you drink alcoholic beverages?
 Every day Less than once a month
 At least once a week, not daily I do not drink alcoholic beverages
 At least once a month, not weekly
17. Prior to your pregnancy, about how many alcoholic beverages did you usually have per occasion?
 (1 = one can of beer, one wine cooler, one glass of wine, or one shot of liquor)
 3 or more
 1 to 2
 I do not drink alcoholic beverages

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18. Which statement best describes your smoking status?
- I have never smoked or have smoked less than 100 cigarettes in my lifetime.
 - I stopped smoking before I found out I was pregnant, and I am not smoking now.
 - I stopped smoking after I found out I was pregnant, and I am not smoking now.
 - I smoke some now, but have cut down on the number of cigarettes I smoke since I found out I was pregnant.
 - I smoke regularly now, about the same as before I found out I was pregnant.

Yes No 19. Have you taken any over-the-counter or prescription medications, used marijuana or "street" drugs during this pregnancy? If, yes list drugs.

Yes No 20. Have you ever sought and/or received treatment for alcohol or drug problems? how long ago? _____

A test for HIV is strongly recommended for all pregnant women, regardless of your responses to the next questions. The test is voluntary. There are three reasons to be tested: (1) most women do not consider themselves at risk or are not aware of their partner's risky behaviors; (2) new medications are available to reduce the chance of an infected mother passing HIV to her baby; and (3) most women do not know if they are infected with HIV until late in the disease. The following questions will help your health care provider determine other areas for counseling and evaluation.

- Yes No Unsure 21. Have you or your sexual partners ever had a sexually transmitted disease (STD or VD) such as chlamydia, gonorrhea, syphilis, or herpes?
- Yes No Unsure 22. Have you ever had a serious pelvic infection or pelvic inflammatory disease (PID)?
- Yes No Unsure 23. Do you think any of your male sexual partners have ever had sex with other men?
- Yes No Unsure 24. Have you or your sexual partners ever used IV street drugs?
- Yes No Unsure 25. Have you had sex with two or more partners in the last twelve months?
- Yes No Unsure 26. Do you think any of your sexual partners may have HIV or AIDS?
- Yes No Unsure 27. Have you or your sexual partners ever had a blood transfusion?

How safe you feel in your daily living gives us important information about risks to you and your baby. Please answer these questions as well as you can.

28. Do you feel safe...
- Yes No - in your personal relationship?
- Yes No - within your home?
- Yes No - in your own neighborhood?
- Yes No - other (specify) _____
- Yes No 29. Have you ever had your feelings repeatedly hurt, been repeatedly put down, or experienced other kinds of hurting?

If you're under 18, and you answer "yes" to the following questions, your care provider must report this information to Child Protective Services.

- Yes No 30. Are you being or have you ever been hit, slapped, kicked, pushed, or otherwise physically hurt? If yes, by whom?
- Husband Family Member
 - Ex-husband Stranger
 - Partner Other (specify) _____
- Yes No 31. Are you experiencing or have you ever experienced uncomfortable touching or forced sexual contact? If yes, by whom?
- Husband Family Member
 - Ex-husband Stranger
 - Partner Other (specify) _____