Nash OB-GYN ASSOCIATES, P.A.

Prenatal History

Revised 02/15/16

Patient's Name: _____ Date of Birth: _____

MENSTRUAL HISTORY:

What was the first day of your last menstrual cycle [period]: _____ Are you certain of this date? ❑ Yes ❑ No

Was this a normal menstrual cycle? ❑ Yes ❑ No [If no, explain what was different] _____

Before this pregnancy, how often did you have a menstrual cycle? _____ At what age did your menstrual cycles begin: _____

Were you taking birth control pills when you got pregnant? ❑ Yes ❑ No Date of 1st positive pregnancy test: _____

Place of pregnancy test: ❑ Home ❑ Health Department ❑ Pregnancy Care Center ❑ Primary Doctor ❑ Hospital

Have you been seen by any other doctor, clinic, hospital, or emergency room for problems related to this pregnancy? ❑ Yes ❑ No
If yes, give date, location, and problem seen for: _____

PREGNANCY HISTORY:

How many pregnancies have you had? [including this pregnancy] _____
How many were: full term? [over 37 wks.] _____ Premature? _____
How many living children do you have? _____

How many times have you had a:
❑ Miscarriage ____ ❑ Ectopic [tubal pregnancy] ____ ❑ Stillbirth ____ ❑ Elective abortion/Termination_____

Did you have any problems with any pregnancies? ❑ Yes ❑ No
If yes, please explain: _____

Did any babies weigh less than 5½ pounds at birth? ❑ Yes ❑ No
Did any babies weigh more than 9 pounds at birth? ❑ Yes ❑ No

Did your mother take a medication DES (Diethylstilbestrol) when she was pregnant with you? ❑ Yes ❑ No

Did you have a positive Group B strep test with a previous pregnancy? ❑ Yes ❑ No

Will you be 35 or older at the time the baby is born? ❑ Yes ❑ No
Will the father be 50 years or older at the time the baby is born? ❑ Yes ❑ No

EXPOSURES AFFECTING HEALTH:

Have you had any rash or viral illness since your last menstrual period? ❑ Yes ❑ No

List any medications you are CURRENTLY taking:
[include prescriptions, over the counter, vitamins & supplements, herbal medicines] _____
_____

List any medications you have taken since your last menstrual period. _____

Have you had an x-ray since you have been pregnant? ❑ Yes ❑ No If yes, what was x-rayed? _____

Are you exposed to chemicals or hazardous substances in your workplace? ❑ Yes ❑ No

Have your every had any sexually transmitted infections? [check all that apply]
❑ Syphilis ❑ Gonorrhea ❑ Chlamydia ❑ Venereal warts ❑ PID [pelvic inflammatory disease]
If yes, when, how, and where were you treated? _____

Have you or your partner ever had genital herpes? ❑ Yes ❑ No

Have you ever been diagnosed with HIV/AIDS or is it possible that you may have been exposed to HIV? ❑ Yes ❑ No
[history of blood transfusion, IV drug use, multiple sex partners, sexual exposure to a gay or bisexual partner, exposure to IV drug user]

Have you ever used any of the following substances?
Tobacco products [cigarettes, cigars, snuff, or chewing tobacco] ❑ Currently using ❑ Used in past ❑ Never used
Alcohol [beer, liquor, or wine] ❑ Currently using ❑ Used in past ❑ Never used
Street drugs [ex.: marijuana, cocaine, heroin, meth, LSD] ❑ Currently using ❑ Used in past ❑ Never used
Prescription drug abuse [ex.: pain pills] ❑ Currently using ❑ Used in past ❑ Never used

CONTINUED ON REVERSE SIDE ➤

GENETIC SCREENING:

Do you or the baby's father have any birth defects? ❑ Yes ❑ No
If yes, please describe: _____

Have you or the baby's father had a child born with a birth defect? ❑ Yes ❑ No
If yes, please describe: _____

Have you or the baby's father had a history of pregnancy losses [miscarriages or stillborns]?
❑ Yes (Mother of baby) ❑ Yes (Father of baby)
If yes, have either of you had genetic counseling? ❑ Yes ❑ No
If yes, have either of you had chromosomal testing? ❑ Yes ❑ No
Where & what were the results? _____

Some genetic problems occur more frequently in couples with certain racial or ancestral backgrounds.
Please check if you are or the baby's father is of any of these backgrounds.

African American/Black: ❑ Yes (Mother of baby) ❑ Yes (Father of baby)
Has either of you been tested for sickle cell trait? ❑ Yes ❑ No
Mother's sickle cell result _____ Father's sickle cell result _____

Jewish ancestry/Eastern European descent: ❑ Yes (Mother of baby) ❑ Yes (Father of baby)
If yes, has either of you been tested for Tay Sachs? ❑ Yes ❑ No
If yes, has either of you been tested for Canavans disease? ❑ Yes ❑ No
Mother's result _____ Father's result _____

European ancestry: ❑ Yes (Mother of baby) ❑ Yes (Father of baby)
If yes, has either of you had cystic fibrosis testing? ❑ Yes ❑ No
Mother's result _____ Father's result _____

Mediterranean, Greek, Italian, Cajun, French Canadian or Asian ancestry: ❑ Yes (Mother of baby) ❑ Yes (Father of baby)
If yes, has either of you been tested for inherited forms of anemia or Thalassemia? ❑ Yes ❑ No
Mother's result _____ Father's result _____

Was anyone in your family or the baby's father's family born with any disorder which you think might be inherited? ❑ Yes ❑ No
If yes, please give the family relation [parents, siblings, grandparents, this can include distant relatives].

DISORDER	FAMILY RELATION
❑ Congenital Heart Defects	_____
❑ Cleft Lip or Palate	_____
❑ Down's Syndrome	_____
❑ Hemophilia or Blood Disorders	_____
❑ Huntington's Chorea	_____
❑ Neural Tube Defect (Spina Bifida, Anencephaly, Meningomyelocete)	_____
❑ Muscular Dystrophy	_____
❑ Mental Retardation or Autism	_____
❑ Other Genetic or Chromosomal Disorders	_____
❑ Three or more first-trimester misarriages (less than 14 weeks)	_____
❑ Stillborns	_____
❑ Multiple Births (Twins, Triplets, etc)	_____

CURRENT PREGNANCY CONCERNS:

Check any of the following problems that you are currently experiencing:

❑ Nausea ❑ Vomiting ❑ Breast tenderness ❑ Frequent urination ❑ Headaches
❑ Vaginal bleeding ❑ Abdominal cramping ❑ Abdominal pain ❑ Burning or pain with urination

❑ Other _____ Explain: _____

_____

_____

_____