Washington University in St. Louis
Physicians

Dear Ms. _____

Your **ultrasound** appointment: _____
Please arrive 20 minutes prior to your ultrasound appointment to complete registration.

☐ **Ultrasound not needed at this time**

Maternal-Fetal Virtual Consult: _____

Please be sure to complete the enclosed paperwork and bring it with you to your appointment. This assures that we will be able to address all issues pertinent to your specific situation at the time of your consultation. If you have any questions, please call 314-454-8181 during the hours of 8am-4pm, Monday through Friday.

If you don't have your paperwork filled out prior to your appointment, please arrive 30 minutes early to complete - this may result in delayed appointment time.

If you are less than 25 weeks pregnant and having an ultrasound, it is necessary for you to have a "full bladder". We recommend that you drink 24 ounces of clear fluid, one hour prior to your ultrasound appointment time.

On the day of your appointment, please bring your insurance card, photo identification, referral form, and any applicable fees with you. Please allow at least 2 hours for your appointment. If you need help finding the hospital, please call (618) 549-0721 for directions.

Please let us know if you must cancel or reschedule your appointment, by calling 314-454-8181.

Washington University in St. Louis Physicians

Medical and Obstetrical Questionnaire

Welcome. The following questionnaire is used to obtain as much pertinent medical information about you as possible so that any factors significant to your pregnancy will be identified. All information is confidential, so please provide answers that are as accurate as possible. **Please Print Clearly. Thank you!**

Name _____ Age ____ Date of Birth _____

Contacts: Cell_____ Email _____

Referring Physician/Provider_____

Reason for Referral_____

PREGNANCY HISTORY

When was the **first day** of your last menstrual period _____

Did you get pregnant by means of in-vitro fertilization (IVF) in your current pregnancy? . . . . . ☐ Yes ☐ No

How many times have you been pregnant (including current pregnancy)? _____

How many **full term** pregnancies have you had (37 weeks or more)?_____

How many **preterm** pregnancies have you had (20-36 weeks)?_____

How many **miscarriages (<20 weeks)** have you had? _____

How many less than10 weeks? _____

How many 10-19 weeks? _____

How many **tubal or ectopic pregnancies** have you had? _____

How many elective **abortions** or pregnancy **terminations** have you had?_____

How many **multiple** pregnancies have you had (twins, triplets, quads)?_____

How many **living** children do you have? _____

Please fill out the following page with more details about your pregnancies.

GYNECOLOGIC HISTORY

Have you ever been diagnosed with a sexually transmitted infection (herpes/HSV, gonorrhea, chlamydia, hepatitis, HIV, trichomoniasis? . . . . . ☐ Yes ☐ No

Have you ever had a pap smear that was not normal? . . . . . ☐ Yes ☐ No

If yes, when? _____

When was your last pap smear?_____ Was it normal?. . . . . ☐ Yes ☐ No

Have you ever been told you have a uterine anomaly (bicornuate uterus, didelphys, uterine septum, etc)? . . . . . ☐ Yes ☐ No

Do you have a history of fibroids? . . . . . ☐ Yes ☐ No

PREVIOUS PREGNANCY HISTORY

For all pregnancies, please provide as much of the following information as possible.

Date of Delivery	Weeks or Months Pregnant	Length of Labor	Baby's birth weight	Sex of baby	Delivery type	Anesthesia used	Hospital where delivered	Is the baby still living	Did you have Preterm Labor?
		Hours	lbs oz	☐ Male ☐ Female	☐ Vaginal ☐ C-Section			☐ Yes ☐ No	☐ Yes ☐ No
	Please explain any complications:								☐ None
		Hours	lbs oz	☐ Male ☐ Female	☐ Vaginal ☐ C-Section			☐ Yes ☐ No	☐ Yes ☐ No
	Please explain any complications:								☐ None
		Hours	lbs oz	☐ Male ☐ Female	☐ Vaginal ☐ C-Section			☐ Yes ☐ No	☐ Yes ☐ No
	Please explain any complications:								☐ None
		Hours	lbs oz	☐ Male ☐ Female	☐ Vaginal ☐ C-Section			☐ Yes ☐ No	☐ Yes ☐ No
	Please explain any complications:								☐ None
		Hours	lbs oz	☐ Male ☐ Female	☐ Vaginal ☐ C-Section			☐ Yes ☐ No	☐ Yes ☐ No
	Please explain any complications:								☐ None
		Hours	lbs oz	☐ Male ☐ Female	☐ Vaginal ☐ C-Section			☐ Yes ☐ No	☐ Yes ☐ No
	Please explain any complications:								☐ None
		Hours	lbs oz	☐ Male ☐ Female	☐ Vaginal ☐ C-Section			☐ Yes ☐ No	☐ Yes ☐ No
	Please explain any complications:								☐ None

MEDICAL HISTORY

Do you have any chronic medical problems? (Please check all that apply)

- ☐ NONE
- ☐ Thyroid disease
- ☐ Diabetes
- ☐ Chronic hypertension (high blood pressure)
- ☐ Kidney disease
- ☐ Infectious disease (HIV, Hep B or C)
- ☐ Seizure disorder
- ☐ Sickle cell disease
- ☐ Depression/Anxiety/Mental illness
- ☐ Blood clots/Blood disorder
- ☐ Autoimmune disorder
- ☐ Lupus/SLE
- ☐ Asthma
- ☐ Heart Disease
- ☐ Cancer
- ☐ Obesity

☐ Other – please describe _____

CURRENT MEDICATIONS

Please list any medications, vitamins, or supplements you are currently taking (or have taken during this pregnancy).

Medication	Date	Amount	Medication	Date	Amount

SURGICAL HISTORY

Have you had any **gynecological** surgeries? ☐ Yes ☐ No If yes:

Surgery	Year	Hospital

Have you had any **other** surgeries? ☐ Yes ☐ No If yes:

Surgery	Year	Hospital

ALLERGIES

Are you allergic to any medication(s)? ☐ Yes ☐ No If yes:

Medication	Reaction	Medication	Reaction

Are you allergic to Latex? ☐ Yes ☐ No

Any other significant allergies? ☐ Yes ☐ No

SOCIAL HISTORY

What is your occupation? _____ Employer_____

What is your marital status? ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated ☐ Partnered

Who lives with you? _____

Do you currently smoke cigarettes, cigars, E cigs? . . . . . ☐ Yes ☐ No

Average number of cigarettes per day (20 cigarettes to a pack)_____ Quit date _____

During this pregnancy, have you consumed beer, wine or liquor? . . . . . ☐ Yes ☐ No

Have you ever tried/used street drugs or marijuana? . . . . . ☐ Yes ☐ No

What, when, and for how long? _____

GENETIC SCREENING

The following questions help identify pregnancies at risk for common genetic conditions or abnormalities.

Are the two of you related to each other? (i.e., siblings, cousins) . . . . . ☐ Yes ☐ No If yes:

Please describe your relationship _____

What is YOUR race/ethnicity?

- ☐ African American
- ☐ Ashkenazi Jewish
- ☐ Asian
- ☐ Asian Indian
- ☐ Caribbean
- ☐ Caucasian/White
- ☐ French Canadian
- ☐ Latino/Hispanic
- ☐ Mediterranean (Italian, Greek, Yugoslav, etc.)
- ☐ Middle Eastern
- ☐ Northern European (England, Ireland, Germany, etc.)
- ☐ South Pacific Islander

What is the FATHER OF YOUR BABY'S race/ethnicity?

- ☐ African American
- ☐ Ashkenazi Jewish
- ☐ Asian
- ☐ Asian Indian
- ☐ Caribbean
- ☐ Caucasian/White
- ☐ French Canadian
- ☐ Latino/Hispanic
- ☐ Mediterranean (Italian, Greek, Yugoslav, etc.)
- ☐ Middle Eastern
- ☐ Northern European (England, Ireland, Germany, etc.)
- ☐ South Pacific Islander

FAMILY HISTORY

Please answer the following questions regarding **your family history and the father of the baby's family history, including yourselves.**

Has anyone in your family had an open spine (spina bifida) or other neural tube defects? ☐ Yes ☐ No If yes:
Relationship_____

Has anyone in your family had Down Syndrome? ☐ Yes ☐ No If yes:
Relationship_____

Has anyone in your family had any other chromosome abnormalities? ☐ Yes ☐ No If yes:
Relationship and what kind _____

Is there any family history of hemophilia, sickle cell, or other bleeding/blood clotting disorder? ☐ Yes ☐ No If yes:
Relationship_____

Is there any family history of muscular dystrophy? ☐ Yes ☐ No If yes:
Relationship_____

Is there any family history of cystic fibrosis? ☐ Yes ☐ No If yes:
Relationship_____

Is there any family history of mental retardation or Fragile X? ☐ Yes ☐ No If yes:
Relationship _____ and was that person tested for Fragile X? ☐ Yes ☐ No

Is there any family history of Huntington disease? ☐ Yes ☐ No If yes:
Relationship_____

Is there any family history of other birth defects or genetic disorders? ☐ Yes ☐ No If yes:
Relationship and what kind _____

PATERNAL (BABY'S FATHER) HISTORY

Name_____ Date of Birth_____ Age_____

Employer _____ Occupation _____

Does the baby's father have any chronic medical problems? (Please check all that apply)

- ☐ NONE
- ☐ Thyroid disease
- ☐ Diabetes
- ☐ Chronic hypertension (high blood pressure)
- ☐ Kidney disease
- ☐ Infectious disease (HIV, Hep B or C)
- ☐ Seizure disorder
- ☐ Sickle cell disease
- ☐ Depression/Anxiety/Mental illness
- ☐ Blood clots/Blood disorder
- ☐ Autoimmune disorder
- ☐ Lupus/SLE
- ☐ Asthma
- ☐ Heart Disease
- ☐ Cancer
- ☐ Obesity
- ☐ Other – please describe _____

Current Medication

What, if any, medications, vitamins, or supplements does the baby's father take on a regular basis?

_____ _____ _____

_____ _____ _____

_____ _____ _____

_____ _____ _____

The above information is accurate to the best of my knowledge.

Patient's Signature_____ Date_____