Washington University in St. Louis Physicians

Welcome!

Department of Obstetrics and Gynecology – Maternal-Fetal Medicine Division
Medical and Obstetrical Questionnaire

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_____ Date of Birth _____

PREGNANCY HISTORY

Including this pregnancy, how many times have you been pregnant?_____

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

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

Please check one — Is this date: ☐ Definite ☐ Approximate ☐ Unknown

Please list any other drugs or medications you have taken during this pregnancy.

Medication	Date	Amount	Medication	Date	Amount

Do you have any chronic medical problems? (Please check all that apply) . . . . . ☐ Yes ☐ No If yes:

- ☐ Thyroid disease
- ☐ Blood clots
- ☐ Insulin dependent diabetes
- ☐ Non-insulin dependent diabetes
- ☐ Gestational diabetes (diabetes during pregnancy only)
- ☐ Chronic hypertension (high blood pressure)
- ☐ Kidney disease – specific type _____
- ☐ Heart disease – specific type_____
- ☐ Seizure disorder – specific type _____
- ☐ Sickle cell disease
- ☐ Lupus
- ☐ Asthma, allergies, hayfever
- ☐ Blood disorder - specific type_____
- ☐ Other – please describe_____

ALLERGIES

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

Medication	Reaction	Medication	Reaction

ALLERGIES continued

Are you allergic to Latex? . . . . . ☐ Yes ☐ No If yes:

What kind of reaction did you have? _____

Are you allergic to other things (e.g., pollen, molds, dust, foods)? . . . . . ☐ Yes ☐ No If yes:

Allergen	Treatment	Allergen	Treatment
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

OTHER INFORMATION

Do you plan to: ☐ Breast-feed or ☐ Bottle-feed your baby

If you have a boy, do you plan to have him circumcised?. . . . . ☐ Yes ☐ No

Are you planning to have a permanent form of
sterilization for you or your partner after delivery? . . . . . ☐ Yes ☐ No

Are you planning to attend prenatal classes? . . . . . ☐ Yes ☐ No

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

Patient's Signature_____ Date_____

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

If you, or the baby's father, are **Jewish or French Canadian**
have you been screened for Tay-Sachs Disease? . . . . . ☐ Yes ☐ No If yes:

What were the results? Baby's Mother: ☐ Carrier ☐ Negative

Baby's Father: ☐ Carrier ☐ Negative

If you, or the baby's father are African-American have you been screened
for Sickle Cell Disease or Sickle Cell Trait? . . . . . ☐ Yes ☐ No If yes:

What were the results? Baby's Mother: ☐ Disease ☐ Trait

Baby's Father: ☐ Disease ☐ Trait

If you, or the baby's father, are **Italian, Greek, Mediterranean, Asian Indian,**
Southeast Asian, or Chinese have you been screened for Beta-Thalassemia minor?. . . . . ☐ Yes ☐ No If yes:

What were the results? Baby's Mother: ☐ Positive ☐ Negative

Baby's Father: ☐ Positive ☐ Negative

FAMILY HISTORY

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? ☐ 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 sickle cell disease? ☐ Yes ☐ No If yes:

Relationship _____

Is there any family history of mental retardation? ☐ 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 _____

Highest Level of Education Attained

☐ Elementary ☐ High School Graduate ☐ Four-year College Graduate
☐ Some High School ☐ Some College or Trade School ☐ Higher Degree

Were you born with any birth defects? ☐ Yes ☐ No If yes:

Please describe and indicate if corrected by surgery _____

PATERNAL (BABY'S FATHER) HISTORY continued

Do you have any chronic medical problems? (Please check all that apply) . . . . . ☐ Yes ☐ No If yes:

	Date of Diagnosis	Current Status	Medications Currently Taking for this Condition
☐ Insulin dependent diabetes			
☐ Non-insulin dependent diabetes			
☐ Chronic hypertension (high blood pressure)			
☐ Kidney disease specific type			
☐ Heart disease specific type			
☐ Seizure disorder specific type			
☐ Sickle cell disease			
☐ Lupus			
☐ Asthma, allergies, hayfever			
☐ Blood disorder specific type			
☐ Other describe			
describe			

What other, if any, drugs or medications do you take on a regular basis?

Have you had any X-rays within one month of conception? . . . . . ☐ Yes ☐ No If yes:

What type:

☐ Dental ☐ IVP-Kidney ☐ Barium Enema or Lower GI series

☐ Other Pelvic or Abdomen ☐ Other

Are you occupationally exposed to radiation or toxic substances? . . . . . ☐ Yes ☐ No If yes:

If yes, please indicate type and amount of exposure

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

Patient's Signature Date

PREVIOUS PREGNANCY HISTORY

For all pregnancies that DELIVERED AFTER FOUR MONTHS, 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	Type of Delivery	Anesthesia Used	Hospital where Delivered	Is the Baby Still Living?	Did You Have Preterm Labor?	Please explain any complications
		hours	lbs oz	☐ Male ☐ Female	☐ Vaginal ☐ C-Section			☐ Yes ☐ No	☐ Yes ☐ No	☐ None
		hours	lbs oz	☐ Male ☐ Female	☐ Vaginal ☐ C-Section			☐ Yes ☐ No	☐ Yes ☐ No	☐ None
		hours	lbs oz	☐ Male ☐ Female	☐ Vaginal ☐ C-Section			☐ Yes ☐ No	☐ Yes ☐ No	☐ None
		hours	lbs oz	☐ Male ☐ Female	☐ Vaginal ☐ C-Section			☐ Yes ☐ No	☐ Yes ☐ No	☐ None
		hours	lbs oz	☐ Male ☐ Female	☐ Vaginal ☐ C-Section			☐ Yes ☐ No	☐ Yes ☐ No	☐ None
		hours	lbs oz	☐ Male ☐ Female	☐ Vaginal ☐ C-Section			☐ Yes ☐ No	☐ Yes ☐ No	☐ None