CENTER FOR
WOMEN'S HEALTH
Comprehensive, personalized care you can trust

Date_____

Name_____

Address_____

Phone #_____ Cell_____

DOB_____ Age_____ Marital Status_____

Spouse/Father of Baby_____ Phone #_____

Emergency Contact _____ Phone #_____

Referred by_____

Height _____ Pre-Pregnancy Weight_____

Drug Allergies_____

Religious Preference_____

First day of last menstrual period_____

Were your menstrual periods regular? Yes No

Were you on birth control when you became pregnant? Yes No

Highest Level of education completed_____

How many times have you been pregnant (count this pregnancy) _____

List your children born below:

Date	Sex	Birth Weight	Length of Labor	Anesthesia	Complications	Hospital
1.						
2.						
3.						
4.						
5.						
6.						

List the dates of any miscarriages_____

Do **you** have a history of any of the following?

Drug Allergies	Yes	No
Food Allergies	Yes	No
Diabetes	Yes	No
High blood pressure	Yes	No
Heart Disease	Yes	No
Tuberculosis	Yes	No
Breast Problems	Yes	No
Autoimmune Disorders	Yes	No
Kidney Disease	Yes	No
Urinary Tract Infections	Yes	No
Nervous System Disorders	Yes	No
Epilepsy	Yes	No
Psychiatric/Emotional Disorders	Yes	No
Hepatitis	Yes	No
Liver Disease	Yes	No
Varicose Veins/Phlebitis	Yes	No
Thyroid Problems	Yes	No
Victim of Trauma	Yes	No
Victim of Domestic Violence	Yes	No
Blood Transfusion	Yes	No
Asthma	Yes	No
DES Exposure	Yes	No
Infertility	Yes	No
Uterine Abnormalities	Yes	No

Do you smoke? Yes No

How many cigarettes per day before pregnancy?_____

How many cigarettes per day now?

Do you drink alcohol? Yes No

Amount per week before pregnancy?_____

Amount per week now?_____

Have you ever used street drugs? Yes No

Name of drug(s)_____

Frequency of use_____

Last time used_____

List all medications taken since last menstrual period:

_____

_____

_____

What is your blood type?_____

When was your last pap smear?_____

Have you ever had an abnormal pap?_____

When?_____ At which doctor's office?_____

What type?_____

Have you ever had any gynecological surgeries? Yes No

When_____ Where_____

What surgery?_____

Please list all surgeries you have had including year performed:

_____

_____

Did you have any anesthesia complications with your surgeries? Yes No

Have you been hospitalized for anything other than your surgeries? Yes No

Do you have any family history that is relevant to your pregnancy care? Yes No

Do YOU, THE BABY'S FATHER, or ANYONE IN EITHER FAMILY have a history of:

Thalassemia (anemia associated with Greek, Mediterranean or Asian background)?	Yes	No
Neural Tube Defect (meningomyocle, spina bifida, anencephaly)	Yes	No
Congenital Heart Defect	Yes	No
Downs Syndrome	Yes	No
Tay-Sachs	Yes	No
Sickle Cell Disease or Trait (African Americans)	Yes	No
Hemophilia (free bleeder)	Yes	No
Muscular Dystrophy	Yes	No

Cystic Fibrosis	Yes	No
Huntington Chorea	Yes	No
Mental Retardation	Yes	No
Autism	Yes	No
Any other inherited genetic or chromosomal disorder	Yes	No
Maternal Metabolic Disorders	Yes	No
Have you or the baby's father had a child with any birth defects not listed above?	Yes	No
History of frequent pregnancy loss or stillbirth	Yes	No
Are you at high risk for Hepatitis B	Yes	No
Have you been immunized for Hepatitis B	Yes	No
Do you now or have you ever lived with someone who has TB	Yes	No
Do you or your partner have genital herpes	Yes	No
Have you had a rash or viral illness since your last menstrual period	Yes	No
Do you have a history of any sexually transmitted diseases (gonorrhea, Chlamydia, HPV, syphilis, HIV) Please list dates and treatment received_____	Yes	No
Do you plan to have an epidural (spinal) Anesthesia for your delivery	Yes	No
Do you voluntarily submit to random drug screens	Yes	No

I have read this questionnaire carefully and answered these questions truthfully to the best of my knowledge. I understand that this will become part of my medical record. I also understand that any non-compliance, which includes, but is not limited to, missing appointments, failure to complete lab work, or positive drug screens will result in dismissal from this clinic and referral to the high risk clinic at LSU Conway.

Signed_____ **Date**_____