PATIENT NAME: ______________________________

DATE OF BIRTH: ______________________________

PERINATAL HISTORY QUESTIONNAIRE

This form was designed to assist the perinatologists and your care team to address high-risk issues that may impact your pregnancy.
If you do not wish any of this history to be discussed in front of your family members or guests in the room, please note below.

About You and Your Partner:	You	Your Partner
Name		
Age		
Occupation		
Last grade of school completed		
Ethnic background		
Religion		
Race		
Adopted?	☐ Yes ☐ No	☐ Yes ☐ No

Is anything bothering you physically today? ☐ Yes ☐ No If so, please list: ______________________________

Are you currently pregnant? ☐ Yes ☐ No If so, what is your due date? ______________________________

Have you had any ultrasounds this pregnancy **outside** of St. Luke's? If so, where? ______________________________

Pregnancy History:

Total # times pregnant including current	# of full term (≥37 weeks births	# of preterm (<37 weeks) births	# pregnancy terminations	# of miscarriages	# of living children

Obstetric History: Please list details on each pregnancy below. If you don't remember some details, it is OK to estimate or guess.

DELIVERIES THAT RESULTED IN A LIVE BIRTH:

Date/month/year of delivery	# completed weeks, OR, full term or preterm? (OK to guess)	Infant weight (if known)	Delivery route (vaginal or cesarean)	Boy or Girl	Complications such as preeclampsia or high blood pressure, diabetes, hemorrhage, blood transfusion, shoulder dystocia, small baby, low fluid, preterm delivery or labor, ICU admission for you, NICU stay for baby, etc.

MISCARRIAGES, ABORTIONS (PREGNANCY TERMINATION), or STILLBIRTHS:

Date/month/year (OK to estimate) or guess	How far along were you when this occurred (# weeks or trimester)	Was this a miscarriage, abortion or stillbirth?	Was surgery performed?	If miscarriage or stillbirth, was a cause found?	Complications or comments

Are you and your partner related? ☐ Yes ☐ No

Questions pertaining to pregnancies conceived by IVF: Date of transfer? ______________ Was egg donor used? ☐ Yes (age: _______)

embryos transferred: ______________________________ Was PGS or PGD done? ☐ Yes ☐ No

Age of embryo at transfer (5 day, etc): ______________________________

Name of reproductive endocrinologist: ______________________________

PATIENT NAME: ______________________________

DATE OF BIRTH: ______________________________

PERINATAL HISTORY QUESTIONNAIRE

Your Medical History: Please check yes if there is a personal history (**in YOU**) of the following conditions.

Condition		Details that you find important to share or discuss
Acid reflux requiring medication, or stomach ulcers	☐ Yes ☐ No	
Asthma	☐ Yes ☐ No	
Bariatric (weight loss) surgery	☐ Yes ☐ No	
Blood clot in leg or lungs	☐ Yes ☐ No	
Blood transfusion	☐ Yes ☐ No	
Cancer (**not** including abnormal Pap smears)	☐ Yes ☐ No	
Diabetes (preexisting or gestational)	☐ Yes ☐ No	
Epilepsy or seizure	☐ Yes ☐ No	
Heart defect including valve problem or hole	☐ Yes ☐ No	
Heart disease, including heart attack or rhythm problem	☐ Yes ☐ No	
Hemophilia or Von Willebrand disease	☐ Yes ☐ No	
Hepatitis B or C or HIV	☐ Yes ☐ No	
High blood pressure (hypertension)	☐ Yes ☐ No	
Lupus, Sjogren syndrome, or other autoimmune condition	☐ Yes ☐ No	
Mental illness (ex. depression, anxiety, PTSD, suicide attempt)	☐ Yes ☐ No	
Opiate use disorder/addiction or overdose	☐ Yes ☐ No	
Sexually transmitted infections this pregnancy	☐ Yes ☐ No	
Stroke	☐ Yes ☐ No	
Surgery other than cesarean or bariatric (please list):		
Thyroid problem (hyperthyroid or hypothyroid)	☐ Yes ☐ No	
Are there any other conditions you wish to discuss?	☐ Yes ☐ No	

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DATE OF BIRTH: ___________________________________

PERINATAL HISTORY QUESTIONNAIRE

Substance Use History	Currently	Prior to or at the beginning of pregnancy
How many cigarettes do you smoke daily?		
Do you use marijuana products?	☐ Yes ☐ No	☐ Yes ☐ No
Do you use prescription pain pills, opiates or heroin, cocaine, meth, or other drugs?	☐ Yes ☐ No	☐ Yes ☐ No
Do you drink alcohol?	☐ Yes ☐ No	☐ Yes ☐ No

Medications: Please list your medications and dosages. Office staff will update this in your health record as well.

____

____

____

____

List any allergies to medications: ____

____

____

Family History: Please check or write yes if there is a family history of the following conditions. If you don't know details, that is OK.

Condition	Your **family** (1st degree relatives)	Your **partner or their family**
Ashkenazi Jewish ancestry	☐ Yes ☐ No	☐ Yes ☐ No
Birth defects including heart defects, spina bifida, cleft lip	☐ Yes ☐ No	☐ Yes ☐ No
Blindness or deafness from birth	☐ Yes ☐ No	☐ Yes ☐ No
Blood clot in leg or lungs	☐ Yes ☐ No	☐ Yes ☐ No
Early-onset (< 45 years) breast, ovarian or colon cancer	☐ Yes ☐ No	☐ Yes ☐ No
Death of child within first year of life	☐ Yes ☐ No	☐ Yes ☐ No
Diabetes	☐ Yes ☐ No	☐ Yes ☐ No
Down syndrome **or** other chromosome problem	☐ Yes ☐ No	☐ Yes ☐ No
Genetic condition or carrier for cystic fibrosis, sickle cell, thalassemia, Tay Sachs, or spinal muscular atrophy	☐ Yes ☐ No	☐ Yes ☐ No
Hemophilia or Von Willebrand disease	☐ Yes ☐ No	☐ Yes ☐ No
Preeclampsia or high blood pressure (hypertension)	☐ Yes ☐ No	☐ Yes ☐ No
Intellectual disabilities, including autism or Fragile X	☐ Yes ☐ No	☐ Yes ☐ No
Mental illness	☐ Yes ☐ No	☐ Yes ☐ No
Opiate use disorder/addiction or overdose	☐ Yes ☐ No	☐ Yes ☐ No
Stroke	☐ Yes ☐ No	☐ Yes ☐ No