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 for certain information to be discussed in front of your partner in the room, please denote with a star.

About You	
Occupation:	Last grade of school completed:
Ethnic background:	Race:
Adopted? ☐ Yes ☐ No	Are you and your partner related? ☐ Yes ☐ No

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

What was the first day (of bleeding) of your last menstrual period? __________ If pregnant, what is your due date? ______________

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

Have you had any sexually transmitted infections this pregnancy? ☐ Yes ☐ No If yes, which one(s)? ______________

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

If no egg donor used, your age at egg retrieval for the embryo: _____ # embryos transferred: _____ Was PGS or PGD done? ☐ Yes ☐ No

Age of embryo at transfer (5 day, etc): ____________ Name of reproductive endocrinologist: ______________________

Your Medical and Surgical History: Please Check or circle if there is a personal history (in **YOU**) of the following conditions.		
☐ Depression or other mental illness	☐ Lupus or Sjogren syndrome	☐ Thyroid disease (hypothyroid or hyperthyroid)
☐ Gestational diabetes	☐ Polycystic ovary syndrome (PCOS)	☐ Liver disease
☐ Abnormal ECG	☐ Pulmonary embolism (blood clot in lung)	☐ Myocardial infarction (heart attack)
☐ Alcoholism	☐ Coronary artery disease	☐ Previous opioid use/addiction or overdose
☐ Asthma	☐ Deep vein thrombosis (blood clot in leg)	☐ Sickle cell anemia or sickle cell trait
☐ Cancer (not an abnormal Pap)	☐ Diabetes mellitus	☐ Stroke
☐ Heart failure	☐ Hepatitis B or C	☐ Transient ischemic attack ("ministroke")
☐ Hemophilia or Von Willebrand disease	☐ History of blood transfusion	☐ Heart valve problem or defect (not a murmur)
☐ Stomach ulcers or severe acid reflux	☐ HIV/AIDS	☐ Surgery other than bariatric or cesarean:
☐ Weight loss (bariatric) surgery	☐ Hypertension	
☐ Epilepsy or seizure disorder	☐ Kidney disease	☐ Any other conditions you want to discuss:
☐ Antiphospholipid syndrome	☐ Crohn's disease or ulcerative colitis	

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

____

____

List any allergies to medications: ____

____

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

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PERINATAL HISTORY QUESTIONNAIRE

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 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 (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

Substance Use History	Currently	Any use prior to pregnancy or before knowledge of pregnancy?
How many tobacco cigarettes do you smoke daily?		
Do you vape or use e-cigarettes?	☐ Yes ☐ No	☐ Yes ☐ No
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

Family / Partner History:

Partner Name: ______________________________ Age: ________ Occupation: ______________________________

Last grade of school completed: ________________ Adopted? ☐ Yes ☐ No

Please check if there is a history of the following in your **parents, siblings, or prior children,** or in your partner.

Condition	Your **parents, siblings, or prior children**	Your **partner**
Ashkenazi Jewish ancestry	☐ Yes ☐ No	☐ Yes ☐ No
Birth defects including heart defects, spina bifida, cleft lip	☐ Yes ☐ No	☐ Yes ☐ No
Blood clot in leg or lungs	☐ Yes ☐ No	
Diabetes	☐ Yes ☐ No	
Early-onset breast or ovarian cancer (under age 45)	☐ Yes ☐ No	
Down syndrome or other chromosome problem/syndrome	☐ 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	
Preeclampsia, toxemia, or hypertension	☐ Yes ☐ No	
Opiate use disorder/addiction or overdose	☐ Yes ☐ No	☐ Yes ☐ No