Name: _____ Date of Birth: _____

This form was designed to assist the perinatologists and your care team to address high-risk issues that may impact your pregnancy.

St Luke's UNIVERSITY HEALTH NETWORK

PERINATAL HISTORY QUESTIONNAIRE

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

If you do not wish for certain information to be discussed in front of your support person in the room, please denote with a star.(*)

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

First day (day you **started** bleeding) of last normal menstrual period? _____ If pregnant, what is your due date? _____

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

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.

☐ Asthma	☐ Crohn's disease or ulcerative colitis	☐ Substance use/addiction/overdose or alcoholism
☐ Heart attack or heart failure	☐ Hemophilia or Von Willebrand disease	☐ Sexually transmitted infection this pregnancy
☐ Heart valve problem or defect (not a murmur)	☐ Antiphospholipid syndrome	☐ Thyroid problem (hypothyroid or hyperthyroid)
☐ Hypertension (high blood pressure)	☐ Lupus or Sjogren syndrome	☐ Cancer (not an abnormal Pap)
☐ Heart problems	☐ HIV/AIDS, Hepatitis B or Hepatitis C	☐ Sickle cell anemia or sickle cell trait
☐ Diabetes (type 1 or 2) or gestational	☐ Blood transfusion	☐ Stomach ulcers or severe acid reflux
☐ Polycystic ovary syndrome (PCOS)	☐ Depression or other mental illness	Surgeries:
☐ Blood clot in legs or lungs (DVT or PE)	☐ Epilepsy or seizure disorder	
☐ Kidney disease or liver disease	☐ Stroke or Transient ischemic attack ("ministroke")	☐ Weight loss (bariatric) surgery

Pregnancy History: If you don't remember some details, it is OK to estimate or guess.

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

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: (***If you need more space, write on back of page***)

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

Current Substance Use

How many tobacco cigarettes do you smoke daily?	_____	Do you use prescription pain pills, opiates or heroin, cocaine, meth, or other drugs?	☐ Yes ☐ No
Do you vape or use e-cigarettes?	☐ Yes ☐ No		
Do you use marijuana products?	☐ Yes ☐ No	Do you drink alcohol?	☐ Yes ☐ No

Partner Name: _____ Age: ____ Occupation: _____ Last grade of school completed: _____ Adopted? ☐ Yes ☐ No

Family History: **Please check** if history of the following in your **parents, siblings, or prior children,** or your partner.	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	☐ Yes ☐ No
Preeclampsia, toxemia, or hypertension	☐ Yes ☐ No	
Opiate use disorder/addiction or overdose	☐ Yes ☐ No	☐ Yes ☐ No

Please note that your treating provider may request interprofessional (team-based) care or certain medical discussions on your behalf, including medical consultative discussion and review, which may result in additional charges to insurance if applicable.