UW Medicine
VALLEY
MEDICAL CENTER

PRENATAL HISTORY QUESTIONNAIRE

Having a healthy baby is a special event. Once a baby is born, families take certain precautions to ensure the baby's health and safety. The unborn child deserves similar care.

The following questions will help in the care of your pregnancy. Please answer these questions as well as you cart If you need help answering the questions, please ask your health care provider. The first questions relate to you. The next set of questions will be about you, your baby's father, and both your families. When thinking about your families, please include your child (or unborn baby), mother, father, sisters, brothers, grandparents, aunts, uncles, nieces, nephews, or cousins.

Yes.....No..... 1. Will you be 35 years or older when the baby is due? Age when due:_____

Yes.....No..... 2. Are you and the baby's father related to each other:(i.e. cousins)?

Yes.....No..... 3. Have you had three or more pregnancies that ended in miscarriage?

Yes.....No..... 4. Have you delivered a premature baby (before 37 weeks)?

Yes.....No..... 5. Have you or the baby's father had a stillborn baby, a baby who died around the time of delivery, or a baby who was small for gestational age?

Yes.....No..... 6. Do either you or the baby's father have a birth defect or genetic condition such as a baby born With an open spine (spinabifida), a heart defect, or Down Syndrome?

Yes.....No..... 7. Does anyone in your family or anyone in the baby's father's family have a birth defect or condition that has been diagnosed as genetic or inherited, such as open spine (spinabifida), a heart defect, or Down Syndrome?

Yes.....No..... 8. Do you or anyone in your family or anyone in your baby's father's family have a history of stroke, Deep vein thrombosis is, or other blood clotting disorder?

Yes.....No..... 9. Where your ancestors came from may sometimes give us important information about the health of your baby. Are you or the baby's father from any of the following ethnic/racial groups: Jewish, Black, Asian, Mediterranean.(Greek, Italian)?

Yes.....No..... 10. Have you or the baby's father ever been screened to see if either of you are carriers of the gene for any of the following: Tay-Sachs, Sickle Cell, Thalassemia, or Cystic Fibrosis?

Yes.....No..... 11. Do you think you are at increased risk of having a baby with a birth defect or genetic disorder?
If yes, which defect or disorder? _____
Why do you think you have increased risk? _____

Yes.....No..... 12. At any time during the first two months of your pregnancy have you had a rash or a fever of 103° F or greater?

Sometimes, the unborn baby can be exposed to outside factors that can cause birth defects. The next 8 questions will give us important information about possible exposure to the baby.

Yes.....No..... 13. Have you had any x-rays during this pregnancy?

Yes.....No..... 14. Have you had any alcohol during this pregnancy?

Patient Label

PRENATAL HISTORY QUESTIONNAIRE

PRENATAL HISTORY QUESTIONNAIRE

15. Prior to your pregnancy, how often did you drink alcoholic beverages?

☐ Everyday
☐ At least once a week, not daily
☐ At least once a month, not weekly
☐ Less than once a month
☐ I do not drink alcoholic beverages

16. Prior to your pregnancy, about how many alcoholic beverages did you usually have per occasion? (1 = one can of beer, one wine cooler, one glass of wine, or one shot of liquor)

☐ 1 to 2
☐ 3 or more
☐ I do not drink alcoholic beverages

17. Which statement best describes your smoking status?

☐ I have never smoked or have smoked less than 100 cigarettes in my lifetime.
☐ I stopped smoking before I found out I was pregnant, and I am not smoking now.
☐ I stopped smoking after I found out I was pregnant, and I am not smoking now.
☐ I smoke some now, but have cut down on the number of cigarettes I smoke since I found out I was pregnant.
☐ I smoke regularly now, about the same as before I found out I was pregnant.

Yes.....No..... 18. Have you taken any over-the-counter, prescription, or "street" drugs during this pregnancy? If yes, List drugs: _____

Yes.....No..... 19. Have you ever sought and or received treatment for alcohol or drug problems? If yes, how long ago?

A test for HIV is strongly recommended for all pregnant women, regardless of your responses to the next questions. The test is voluntary. There are three reasons to be tested: [1] most women do not consider themselves at risk or are not aware of their partner's risky behaviors; [2] new medications are available to reduce the chance of an infected mother passing HIV to her baby; and [3] most women do not know if they are infected with HIV until late in the disease. The following questions will help your health care provider determine other areas for counseling and evaluation.

Yes.....No.....Unsure 20. Have you or your sexual partners ever had a sexually transmitted disease (STD or VD) such as chlamydia, gonorrhea, syphilis, or herpes?

Yes.....No.....Unsure 21. Have you ever had a serious pelvic infection or pelvic inflammatory disease (PIO)?

Yes.....No.....Unsure 22. Do you think any of your male sexual partners have ever had sex with other men?

Patient Label

PRENATAL HISTORY QUESTIONNAIRE

Yes.....No.....Unsure 23. Have you or your sexual partners ever used IV street drugs?

Yes.....No.....Unsure 24. Have you had sex with two or more partners in the last twelve months?

Yes.....No.....Unsure 25. Do you think any of your sexual partners may have HIV or AIDS?

Yes.....No.....Unsure 26. Have you or your sexual partners ever had a blood transfusion?

How safe you feel in your daily living gives us important information about risks to you and your baby. Please answer these questions as well as you can.

Yes.....No..... 27. Do you feel safe in your personal relationship?

Yes.....No..... 28. Do you feel safe within your home?

Yes.....No..... 29. Do you feel safe in your own neighborhood?

Yes.....No..... 30. Other (specify): _____

Yes.....No..... 31. Have you ever had your feelings repeatedly hurt, been repeatedly put down, or experienced other kinds of hurting?

If you're under 18, and you answer "yes" to the following questions, your care provider must report this information to Child Protective Services.

Yes.....No..... 32. Are you being or have you ever been hit, slapped, kicked, pushed, or otherwise physically hurt? If yes, by whom?

☐ Husband ☐ Family Member

☐ Ex-husband ☐ Stranger

☐ Partner ☐ Other (specify) _____

Yes.....No..... 33. Are you experiencing or have you ever experienced uncomfortable touching or forces sexual contact? If yes, by whom?

☐ Husband ☐ Family Member

☐ Ex-husband ☐ Stranger

☐ Partner ☐ Other (specify) _____

Patient Label