Overlake Obstetricians and Gynecologists, PC

Prenatal Questionnaire

Patient Full Name: ______________________ Date of Birth: ______________

Father of the Baby Full Name: ______________________ Father of Baby Date of Birth: ______________

While most babies are born healthy, some babies can be born with a birth defect or develop a significant health problem after birth. The following questionnaire is designed to help determine if there are any problems in your family (or the family of the baby's father) which should be discussed and/or further evaluated. Please answer the questions as accurately as possible. If you are unsure about a specific question, please discuss it with your health care provider.

Mother		Father			Questions
Yes	No	Yes	No	1.	Will you or the baby's father be age 35 years or older when the baby is due? **Age(s) when baby is due:**
Yes	No	Yes	No	2.	Are you and the baby's father related to each other (i.e. cousins)?
Yes	No	Yes	No	3.	Have you or the baby's father had two or more pregnancies that ended in miscarriage?
Yes	No	Yes	No	4.	Have you or the baby's father had a stillborn baby or a child who died around the time of delivery?
Yes	No	Yes	No	5.	Have you or the baby's father had a child with a birth defect, genetic condition, or developmental delay?
Yes	No	Yes	No	6.	Do you or the baby's father have a birth defect or genetic condition?
Yes	No	Yes	No	7.	Does your family or the family of the baby's father have members with birth defects or conditions that have been diagnosed as genetic or inherited? Please circle any that apply: Neural Tube Defect · Congenital Heart Defect · Cleft Lip/Palate Muscular Dystrophy · Polycystic Kidney · Diaphragmatic Hernia **Other:**
Yes	No	Yes	No	8.	Are you or the baby's father from any of the following ethnic/racial groups? Jewish · African American · Asian · Mediterranean (Greek or Italian) **Please list your ethnic identity:**
Yes	No	Yes	No	9.	Have you or the baby's father ever been screened to see if you are carriers of the gene for any of the following? Please circle any diseases that apply: Tay-Sachs · Sickle Cell · Thalassemia · Cystic Fibrosis Fragile X Syndrome · Canavan's Disease · Spinal Muscular Atrophy Down's Syndrome · Huntington's Disease · **Other:**
Yes	No	Yes	No	10.	Have you taken any drugs during this pregnancy such as seizure medications, anti-cancer drugs, anticoagulants (blood thinners), lithium, or accutane? **If yes, please list:**
Yes	No	Yes	No	11.	Have you or the baby's father smoked cigarettes, consumed alcohol (more than 2 drinks/glasses per day), or used recreational drugs? **If yes, please list:**
Yes	No	Yes	No	12.	Have you had a fever of 103 degrees or greater or a rash, at any time during the first two months of your pregnancy?
Yes	No	Yes	No	13.	Have you or the baby's father ever had hepatitis or yellow jaundice?
Yes	No	Yes	No	14.	Have you or the baby's father ever had a sexually transmitted disease (syphilis, gonorrhea, chlamydia, HPV)?
Yes	No	Yes	No	15.	Have you or the baby's father ever had herpes or recurrent genital itching, oral or genital sores, or pain which may suggest herpes?
Yes	No	Yes	No	16.	Have you ever had a serious pelvic infection or pelvic inflammatory disease (PID)?
Yes	No	Yes	No	17.	Have you or the baby's father ever had tuberculosis or been exposed to an individual with known or suspected tuberculosis?
Yes	No	Yes	No	18.	Have you had any x-rays during this pregnancy?
Yes	No	Yes	No	19.	Have you or the baby's father ever had a blood transfusion, used IV drugs, or engaged in homosexual activity?
Yes	No	Yes	No	20.	Do you or the baby's father think that you are at increased risk of having a baby with a birth defect or genetic disorder?
Yes	No	Yes	No	21.	Have you ever had chicken pox?
Yes	No	Yes	No	22.	Have you had any immunizations within the last 12 months? (i.e. flu, dtap, hep B, hep A, MMR)

Signature: ______________________ Date: ______________