KAISER PERMANENTE®

PROVIDER / DATE:

MR # _____

Name _____

PRENATAL QUESTIONNAIRE

PATIENT'S NAME (LAST, FIRST, MIDDLE)

ADDRESS | PREVIOUS NAMES

CITY, STATE AND ZIP CODE

IMPRINT AREA

DAY PHONE | EVENING PHONE | MESSAGE PHONE

RACE | RELIGIOUS PREFERENCE | LANGUAGE PREFERENCE | AGE | DATE OF BIRTH

OCCUPATION | EMPLOYER AND CITY | LAST GRADE COMPLETED

MARITAL STATUS
☐ M ☐ S ☐ DP ☐ Sep ☐ D ☐ W

WHAT IS YOUR LIVING SITUATION?
☐ Alone ☐ With baby's father
☐ Parents ☐ Relatives ☐ Friends ☐ Domestic Partner/Partner

FATHER OF BABY / DOMESTIC PARTNER / PARTNER

NAME | ADDRESS IF DIFFERENT FROM ABOVE

DAY PHONE | EVENING PHONE | AGE | RACE | OCCUPATION

DOES FATHER OF BABY/DOMESTIC PARTNER/PARTNER HAVE ANY MEDICAL PROBLEMS / IF YES, DESCRIBE:

CURRENTLY INVOLVED WITH BABY'S FATHER?
☐ Yes ☐ No ☐ N/A

IN CASE OF EMERGENCY CONTACT:

YOUR LAST MENSTRUAL PERIOD

1. Date of the first day of your last period _____
   Was it a normal period? ..... ☐ Yes ☐ No
   Did it occur at the right time? ..... ☐ Yes ☐ No
2. How many days apart are your periods? _____
3. What did you last use for birth control? _____

☐ Depo provera ☐ Norplant ☐ Birth control pills
☐ Diaphragm ☐ Condom/spermicide ☐ IUD
☐ None ☐ Other: _____

When did you stop using it? _____

4. Did you have a pregnancy test? ..... ☐ Yes ☐ No

If yes, what kind? ☐ Urine ☐ Blood DATE: _____

PREVIOUS PREGNANCIES

How many:

1. Pregnancies have you had? (Including current pregnancy)	
2. Deliveries have you had?	
3. Miscarriages have you had?	
4. Abortions have you had?	
5. Living children do you have?	

Provider Comments: _____

PREVIOUS PREGNANCIES continued

Have any of your pregnancies involved:

6. A baby weighing less than 5 lbs 8 oz? ..... ☐ Yes ☐ No
7. A baby weighing more than 9 lbs? ..... ☐ Yes ☐ No
8. Premature labor? (before 8th mo.) ..... ☐ Yes ☐ No
9. Cesarean section? ..... ☐ Yes ☐ No

Provider Comments: _____

PREGNANCY RISK FACTORS

Since the pregnancy began have you?

1. Had vaginal bleeding that required a visit to the Emergency Department? ..... ☐ Yes ☐ No
2. Had any severe nausea and vomiting that required a visit to the Emergency Department? ..... ☐ Yes ☐ No
3. Had a fever higher than 100 degrees? ..... ☐ Yes ☐ No
4. Smoked cigarettes in the last 3 months? ..... ☐ Yes ☐ No
   If yes, about how many per week do you smoke? ..... _____
5. Had any alcoholic beverages? ..... ☐ Yes ☐ No
6. Taken any medications or drugs? ..... ☐ Yes ☐ No
   If yes, LIST: _____
7. At the time you conceived were you ...
   ☐ Wanting to get pregnant, ☐ Wanting to get pregnant, but not at this time, or ☐ Not wanting to get pregnant at all?

Provider Comments: _____

PLEASE GIVE THE YEARS AND PARTICULARS OF ALL PREVIOUS PREGNANCIES

(Fill in "year," "where," "length of pregnancy," "hours of labor," "sex," and "wt." Use a separate sheet of paper if you have had more than 6 pregnancies.)

YEAR	WHERE	LENGTH OF PREGNANCY	HOURS OF LABOR	TYPE OF ANESTHESIA	TYPE OF DELIVERY	SEX	WT	COMPLICATIONS

PATIENT NAME | MR# | PHYSICIAN

YOUR MEDICAL HISTORY	Yes	No	Provider Comments
Are you allergic to any medications?			
If yes, LIST:			
Do you have or have you ever had:			
1. Abnormal Pap test			
2. Anemia/blood transfusions			
3. Arthritis or bone fractures			
4. Asthma			
5. Bleeding tendencies			
6. Blood clots in veins or lungs			
7. Breast surgery			
8. Cancer			
9. Chicken pox			
10. Chlamydia			
11. Diabetes			
12. Frequent bladder infections			
13. Gall bladder disease			
14. Heart disease			
15. Hepatitis			
16. Herpes (you or your partner)			
17. High blood pressure			
18. HIV			
19. HPV or genital warts			
20. Kidney stones			
21. Lung disease			
22. Major surgery/hospitalization			
23. Mental illness / depression			
24. Migraine headaches			
25. Problems w/ anesthesia			
26. Problems getting pregnant/infertility			
27. Seizures/epilepsy			
28. Syphilis			
29. Thyroid problems			
30. Tuberculosis			

FAMILY HISTORY

Has anyone in your family ever had?	Yes	No	Which family member?
1. Asthma?			
2. Tuberculosis?			
3. Heart disease?			
4. Hypertension?			
5. Kidney disease?			
6. Diabetes?			
7. Seizures/epilepsy?			
8. Sickle cell / thalassemia?			
9. Twins?			
10. Birth defects?			

SOCIAL CIRCUMSTANCES

	Yes	No	Provider Comments
1. Have you ever sought professional help for an emotional problem?			
2. Is your work or home stressful?			
3. Is your living situation unsafe/unstable?			
4. Are you constantly dieting?			
5. Do you foresee any problems coming to prenatal checkups?			
6. Do you have any fears about this pregnancy or baby?			
7. Within the last year - or since you have been pregnant - have you been hit, slapped, kicked or otherwise physically hurt by someone?			
8. Are you in a relationship with a person who threatens or physically hurts you?			
9. Has anyone forced you to have sexual activities that made you uncomfortable?			
10. Are you worried about your partner's drug or alcohol use?			

FATHER OF BABY HISTORY (IF APPLICABLE)

Has the father of the baby?	Yes	No	DON'T KNOW	Dr. Comments
1. Had any blood transfusions?				
2. Tested positive for HIV?				
3. Had herpes?				
4. Smoked cigarettes?				

POSTPARTUM CONTRACEPTION

1. Do you plan to begin a birth control method after your baby is born? ..... ☐ Yes ☐ No
2. If yes, what will you use?

☐ Vasectomy ☐ Birth control pills ☐ Diaphragm
☐ Condom/spermicide ☐ IUD ☐ Depo provera
☐ Norplant ☐ Tubal sterilization

Other: _____

Provider Comments: _____

BREAST FEEDING PLAN

1. Do you plan to breastfeed this baby? ..... ☐ Yes ☐ No

REVIEWED BY | Provider Signature | DATE

SIGNED BY | Patient's Signature | DATE