KAISER PERMANENTE®

MR #: _____

Name: _____

# PRENATAL INTAKE QUESTIONNAIRE

IMPRINT AREA

ADDRESS

| CITY | STATE | ZIP CODE |
|---|---|---|
| | | |

| PHONE | DATE OF BIRTH | AGE |
|---|---|---|
| | | |

| IN CASE OF EMERGENCY, CONTACT NAME | CONTACT PHONE NUMBER |
|---|---|
| | |

| ETHNICITY | RELIGIOUS PREFERENCE | LANGUAGE PREFERENCE |
|---|---|---|
| | | |

MARITAL STATUS

☐ Married ☐ Single ☐ Domestic Partner ☐ Separated ☐ Divorced ☐ Widow

OCCUPATION

| EMPLOYER NAME | LOCATION |
|---|---|
| | |

## OB/GYN STATUS:

First day of your last period: _____

Are you currently breastfeeding? ☐ Yes ☐ No

Planned Delivery Site: _____

## PREGNANCY CIRCUMSTANCES:

What is your living situation?

☐ With Baby's Father ☐ Domestic Partner/Partner ☐ Parents ☐ Relatives ☐ Friends ☐ Alone ☐ Other

Spouse/Partner/Significant Other's Name: _____

Spouse/Partner/Significant Other's Contact Phone Number: _____

Is this person the biological father? ☐ Yes ☐ No ☐ Unknown

At the time you became pregnant, were you

☐ Wanting to get pregnant? ☐ Wanting to get pregnant but not at this time?

☐ Not wanting to get pregnant at all?

Do you plan to begin a birth control method after your baby is born? ☐ Yes ☐ No

If so, which one?

Choices:

☐ Abstinence
☐ Birth control patch
☐ Birth control pills
☐ Birth control-vaginal ring
☐ Cervical cap
☐ Condoms
☐ Diaphragm
☐ IUD
☐ Natural family planning
☐ Progesterone injections (Depo Provera)
☐ Spermicide
☐ Subdermal implant (Nexplanon)
☐ Tubal ligation
☐ None
☐ Not applicable
☐ Undecided
☐ Vasectomy
☐ Withdrawal

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

Is this a surrogate pregnancy? ☐ Yes ☐ No

Will this baby be placed for adoption? ☐ Yes ☐ No ☐ Undecided

Is your living situation unsafe/unstable? ☐ Yes ☐ No

Within the last year—or since you have been pregnant—have you been hit, slapped, kicked, or otherwise physically hurt by someone? ☐ Yes ☐ No ☐ Decline

KAISER PERMANENTE®

MR #: _____

Name: _____

## PRENATAL INTAKE QUESTIONNAIRE

IMPRINT AREA

### PREGNANCY CIRCUMSTANCES (continued):

Are you in a relationship with a person who threatens or physically hurts you? ☐ Yes ☐ No

Comments: _____

### PAST MEDICAL HISTORY QUESTIONNAIRE: If already completed online, no need to complete on paper.

| Have you had any of the following medical conditions? | Yes | No | Comments |
|---|---|---|---|
| 1. Abnormal Pap test | ☐ | ☐ | |
| 2. Anemia | ☐ | ☐ | |
| 3. Rheumatoid arthritis | ☐ | ☐ | |
| 4. Lupus | ☐ | ☐ | |
| 5. Blood transfusion | ☐ | ☐ | |
| 6. Bleeding or excessive bruising when you are cut or injured | ☐ | ☐ | |
| 7. Blood clot in your veins | ☐ | ☐ | |
| 8. Blood clot in your lungs | ☐ | ☐ | |
| 9. Cancer | ☐ | ☐ | |
| 10. Chicken pox | ☐ | ☐ | |
| 11. Chicken pox vaccine | ☐ | ☐ | |
| 12. Diabetes, only while pregnant | ☐ | ☐ | |
| 13. Diabetes | ☐ | ☐ | |
| 14. Gallbladder disease | ☐ | ☐ | |
| 15. Heart disease | ☐ | ☐ | |
| 16. High blood pressure | ☐ | ☐ | |
| 17. Hepatitis B | ☐ | ☐ | |
| 18. Hepatitis C | ☐ | ☐ | |
| 19. HIV positive | ☐ | ☐ | |
| 20. Genital warts | ☐ | ☐ | |
| 21. Genital herpes | ☐ | ☐ | |
| 22. Chlamydia | ☐ | ☐ | |
| 23. Syphilis | ☐ | ☐ | |
| 24. Frequent bladder infections | ☐ | ☐ | |
| 25. Kidney stones | ☐ | ☐ | |
| 26. Kidney infection (pyelonephritis) | ☐ | ☐ | |
| 27. Asthma | ☐ | ☐ | |
| 28. Lung disease | ☐ | ☐ | |

KAISER PERMANENTE®

MR #: _____

Name: _____

## PRENATAL INTAKE QUESTIONNAIRE

IMPRINT AREA

## PAST MEDICAL HISTORY QUESTIONNAIRE (continued):

| | | |
|---|---|---|
| 29. TB (tuberculosis) | ☐ | ☐ |
| 30. Depression | ☐ | ☐ |
| 31. Migraine headaches | ☐ | ☐ |
| 32. Problems with getting pregnant/infertility | ☐ | ☐ |
| 33. Seizure/epilepsy | ☐ | ☐ |
| 34. Thyroid problems | ☐ | ☐ |
| 35. Major surgery | ☐ | ☐ |

## OBSTETRIC HISTORY

As part of your prenatal care, it is important to review your prior pregnancy history, including abortions and miscarriages. Please provide details below. If you have more than 5 prior pregnancies, please make a copy of this page for additional information. If your most recent past pregnancy was at Kaiser Permanente, we should have your obstetric history on file. You may skip this section, but please confirm your history with your Ob/Gyn clinician at your next visit.

**PREGNANCY 1:** Outcome: ☐ Delivered baby ☐ Miscarriage ☐ Abortion ☐ Ectopic
Living: ☐ Yes ☐ No ☐ Stillborn ☐ Neonatal demise ☐ Placed for adoption

Child's Name: _____ Delivery Date: _____

**Type of Delivery:**

☐ Vaginal delivery ☐ Vaginal delivery with vacuum ☐ Vaginal delivery with forceps
☐ Vaginal delivery after C-section (VBAC) ☐ C-section (baby too big) ☐ C-section (baby did not tolerate labor)
☐ C-section (breech) ☐ C-section (elective repeat) ☐ C-section (other)
☐ Other: _____

Type of Anesthesia: ☐ None ☐ Local ☐ Epidural ☐ Spinal ☐ General

Length of Pregnancy (weeks): _____ Location of Delivery: _____

Sex of Baby: ☐ Male ☐ Female Weight of Baby (lbs/oz): _____ lbs _____ oz, or _____ kg

Any medical problems during this pregnancy or delivery? _____

If twins or multiple births, list # of babies: _____. Then include the pregnancy in the following sections for each baby's information.

**PREGNANCY 2:** Outcome: ☐ Delivered baby ☐ Miscarriage ☐ Abortion ☐ Ectopic
Living: ☐ Yes ☐ No ☐ Stillborn ☐ Neonatal demise ☐ Placed for adoption

Child's Name: _____ Delivery Date: _____

**Type of Delivery:**

☐ Vaginal delivery ☐ Vaginal delivery with vacuum ☐ Vaginal delivery with forceps
☐ Vaginal delivery after C-section (VBAC) ☐ C-section (baby too big) ☐ C-section (baby did not tolerate labor)
☐ C-section (breech) ☐ C-section (elective repeat) ☐ C-section (other)
☐ Other: _____

Type of Anesthesia: ☐ None ☐ Local ☐ Epidural ☐ Spinal ☐ General

Length of Pregnancy (weeks): _____ Location of Delivery: _____

Sex of Baby: ☐ Male ☐ Female Weight of Baby (lbs/oz): _____ lbs _____ oz, or _____ kg

Any medical problems during this pregnancy or delivery? _____

KAISER PERMANENTE®

MR #: _____

Name: _____

## PRENATAL INTAKE QUESTIONNAIRE

IMPRINT AREA

**PREGNANCY 3:** Outcome: ☐ Delivered baby ☐ Miscarriage ☐ Abortion ☐ Ectopic
Living: ☐ Yes ☐ No ☐ Stillborn ☐ Neonatal demise ☐ Placed for adoption

Child's Name: _____ Delivery Date: _____

**Type of Delivery:**

☐ Vaginal delivery ☐ Vaginal delivery with vacuum ☐ Vaginal delivery with forceps
☐ Vaginal delivery after C-section (VBAC) ☐ C-section (baby too big) ☐ C-section (baby did not tolerate labor)
☐ C-section (breech) ☐ C-section (elective repeat) ☐ C-section (other)
☐ Other: _____

Type of Anesthesia: ☐ None ☐ Local ☐ Epidural ☐ Spinal ☐ General

Length of Pregnancy (weeks): _____ Location of Delivery: _____

Sex of Baby: ☐ Male ☐ Female Weight of Baby (lbs/oz): _____ lbs _____ oz, or _____ kg

Any medical problems during this pregnancy or delivery? _____

---

**PREGNANCY 4:** Outcome: ☐ Delivered baby ☐ Miscarriage ☐ Abortion ☐ Ectopic
Living: ☐ Yes ☐ No ☐ Stillborn ☐ Neonatal demise ☐ Placed for adoption

Child's Name: _____ Delivery Date: _____

**Type of Delivery:**

☐ Vaginal delivery ☐ Vaginal delivery with vacuum ☐ Vaginal delivery with forceps
☐ Vaginal delivery after C-section (VBAC) ☐ C-section (baby too big) ☐ C-section (baby did not tolerate labor)
☐ C-section (breech) ☐ C-section (elective repeat) ☐ C-section (other)
☐ Other: _____

Type of Anesthesia: ☐ None ☐ Local ☐ Epidural ☐ Spinal ☐ General

Length of Pregnancy (weeks): _____ Location of Delivery: _____

Sex of Baby: ☐ Male ☐ Female Weight of Baby (lbs/oz): _____ lbs _____ oz, or _____ kg

Any medical problems during this pregnancy or delivery? _____

---

**PREGNANCY 5:** Outcome: ☐ Delivered baby ☐ Miscarriage ☐ Abortion ☐ Ectopic
Living: ☐ Yes ☐ No ☐ Stillborn ☐ Neonatal demise ☐ Placed for adoption

Child's Name: _____ Delivery Date: _____

**Type of Delivery:**

☐ Vaginal delivery ☐ Vaginal delivery with vacuum ☐ Vaginal delivery with forceps
☐ Vaginal delivery after C-section (VBAC) ☐ C-section (baby too big) ☐ C-section (baby did not tolerate labor)
☐ C-section (breech) ☐ C-section (elective repeat) ☐ C-section (other)
☐ Other: _____

Type of Anesthesia: ☐ None ☐ Local ☐ Epidural ☐ Spinal ☐ General

Length of Pregnancy (weeks): _____ Location of Delivery: _____

Sex of Baby: ☐ Male ☐ Female Weight of Baby (lbs/oz): _____ lbs _____ oz, or _____ kg

Any medical problems during this pregnancy or delivery? _____