

Prenatal Questionnaire

Congratulations! We are happy to share this experience with you.

To provide you and your growing baby the best care during your pregnancy, please complete the attached questionnaire before your appointment. **This questionnaire will help us learn more about you and help us make sure you get personalized care throughout your pregnancy.**

Instructions

Please answer all questions that apply to you as best you can. Questions are on the front and back of each page.

Please complete the form and bring it to your first visit with your provider. Your midwife or doctor will review it with you during this appointment. The information on the questionnaire will help your provider know if you may need any special tests during your pregnancy.

Important:

We want to make sure you get all the information you need and answer any questions you have during your appointment. If you don't have your questionnaire filled out when you show up, we will have you fill it out before you see your care team. **This may shorten your visit time, so it's important for you to complete the form before your appointment.**

If you have questions

If you have any questions or need help filling out the questionnaire, please call the Kaiser Permanente Obstetrics office of your appointment:

- Bellevue Medical Center: 425-502-4230
- Capitol Hill Medical Center (Seattle): 206-326-3500
- Olympia Medical Center: 360-923-7500
- Tacoma Medical Center: 253-596-3540

We look forward to seeing you at your visit!

OB/GYN Care Visit

This worksheet is used to help you and your health care provider determine your pregnancy care needs. We will use this form to enter information into our secure medical record system.

Kaiser Permanente values your privacy. Your answers will be kept confidential.

Personal Information	CLINIC USE ONLY
Your name:	In Epic: Patient Demographic Information
Occupation:	
Are you married? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Are other people living with you? <input type="checkbox"/> Yes <input type="checkbox"/> No	
If yes , who lives with you:	
Religion:	
Language spoken: If you need an interpreter, in what language?	
Ethnic background:	
Father of Baby	CLINIC USE ONLY
Name:	In Epic: Father of Baby
Age:	
Occupation:	
Ethnic background:	
Religion:	
Home phone number:	
Work phone number:	
Cell phone number:	
Have you ever had genetic testing? <input type="checkbox"/> Yes <input type="checkbox"/> No	
If yes , what were you tested for:	

Last Menstrual Period Information	CLINIC USE ONLY
Do you know the day your last menstrual period started? <input type="checkbox"/> Yes <input type="checkbox"/> No	In Epic: New OB Questionnaire
If yes , when did your last menstrual period start (month/day/year):	
Are you sure of this date? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Was your last period normal? <input type="checkbox"/> Yes <input type="checkbox"/> No	
If your periods are not regular: What is the shortest time (in days) from one period to the next? _____ What is the longest time (in days) from one period to the next? _____	
How many days from the beginning of one period to the beginning of the next?	
Symptoms since last menstrual period Do you currently have any of the following symptoms: <input type="checkbox"/> abdominal pain <input type="checkbox"/> blood in the stools or urine <input type="checkbox"/> chest pain <input type="checkbox"/> shortness of breath <input type="checkbox"/> coughing <input type="checkbox"/> vomiting <input type="checkbox"/> pain on urination <input type="checkbox"/> vaginal discharge <input type="checkbox"/> vaginal bleeding <input type="checkbox"/> nausea <input type="checkbox"/> headache <input type="checkbox"/> constipation	
Birth Control and Breastfeeding	CLINIC USE ONLY
Were you taking birth control at the time of conception? <input type="checkbox"/> Yes <input type="checkbox"/> No	In Epic: New OB Questionnaire
Did you take birth control pills before becoming pregnant? <input type="checkbox"/> Yes <input type="checkbox"/> No	
When did you stop taking them (month/day/year):	
Were you breastfeeding at the time of conception? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Vaccinations and Tests	CLINIC USE ONLY
Have you had chicken pox or been vaccinated against Varicella? <input type="checkbox"/> Yes <input type="checkbox"/> No	In Epic: New OB Questionnaire
Have you ever received the Hepatitis B vaccine? <input type="checkbox"/> Yes <input type="checkbox"/> No	
When did you receive your last tetanus vaccine (Tdap):	
We will test you for Hepatitis B. Do you object to this? <input type="checkbox"/> Yes <input type="checkbox"/> No	
We will test you for HIV. Do you object to this? <input type="checkbox"/> Yes <input type="checkbox"/> No	

Pregnancy History	CLINIC USE ONLY
Please answer the following questions for each pregnancy you've had. If you've never been pregnant, please skip to the next section.	In Epic: OB History
How many pregnancies have you had?	
Date of birth or end of pregnancy:	
How many weeks?	
What is the baby's name?	
How much did the baby weigh?	
Do you know what the baby's one and five minute Apgars were? Apgar 1-minute: Apgar 5-minute:	
How long were you in labor?	
Where was the baby delivered?	
What was the name of your pregnancy care provider?	
Did you have anesthetic? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, what kind? <input type="checkbox"/> Subarachnoid block <input type="checkbox"/> IV Analgesic <input type="checkbox"/> Local <input type="checkbox"/> Spinal <input type="checkbox"/> General <input type="checkbox"/> Epidural <input type="checkbox"/> Pudendal	
If you've had a baby, please check the following for your birth: <input type="checkbox"/> Vaginal delivery <input type="checkbox"/> Pregnancy termination (abortion) <input type="checkbox"/> Cesarean section <input type="checkbox"/> Ectopic (tubal) pregnancy <input type="checkbox"/> Help of a vacuum extractor <input type="checkbox"/> Stillbirth <input type="checkbox"/> Help of forceps <input type="checkbox"/> Miscarriage <input type="checkbox"/> Breech birth <input type="checkbox"/> Multiple babies (ie: twins, triplets)	
What was the sex of the baby? <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Unknown <input type="checkbox"/> Other	
Is this child still living? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Were there any complications? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, what?	
Did you go full term or deliver early? <input type="checkbox"/> Full term <input type="checkbox"/> Premature delivery	

Past Medical History	
If you do not know the answer to any of the following questions, please leave blank.	
Neurological	
General neurological problems <input type="checkbox"/> Yes <input type="checkbox"/> No	Stroke <input type="checkbox"/> Yes <input type="checkbox"/> No
Epilepsy <input type="checkbox"/> Yes <input type="checkbox"/> No	Seizures <input type="checkbox"/> Yes <input type="checkbox"/> No
Migraines <input type="checkbox"/> Yes <input type="checkbox"/> No	Headaches <input type="checkbox"/> Yes <input type="checkbox"/> No
Psycho Social	
Postpartum depression <input type="checkbox"/> Yes <input type="checkbox"/> No	
Inpatient psychiatric care <input type="checkbox"/> Yes <input type="checkbox"/> No	
Depression <input type="checkbox"/> Yes <input type="checkbox"/> No	
Domestic violence <input type="checkbox"/> Yes <input type="checkbox"/> No	
Forced sex <input type="checkbox"/> Yes <input type="checkbox"/> No	
Substance abuse <input type="checkbox"/> Yes <input type="checkbox"/> No	
Post traumatic stress disorder (PTSD) <input type="checkbox"/> Yes <input type="checkbox"/> No	
Mood disorder <input type="checkbox"/> Yes <input type="checkbox"/> No	
Difficulty coping <input type="checkbox"/> Yes <input type="checkbox"/> No	
Endocrine	
Thyroid disease <input type="checkbox"/> Yes <input type="checkbox"/> No	
Diabetes mellitus <input type="checkbox"/> Yes <input type="checkbox"/> No	
Infertility <input type="checkbox"/> Yes <input type="checkbox"/> No	
Polycystic ovary syndrome (PCOS) <input type="checkbox"/> Yes <input type="checkbox"/> No	
Respiratory	
Tuberculosis <input type="checkbox"/> Yes <input type="checkbox"/> No	Pulmonary embolism <input type="checkbox"/> Yes <input type="checkbox"/> No
Asthma <input type="checkbox"/> Yes <input type="checkbox"/> No	Other respiratory <input type="checkbox"/> Yes <input type="checkbox"/> No
Pneumonia <input type="checkbox"/> Yes <input type="checkbox"/> No	
Circulatory Problems	
Hypertension <input type="checkbox"/> Yes <input type="checkbox"/> No	Irregular heartbeat <input type="checkbox"/> Yes <input type="checkbox"/> No
Coronary artery disease <input type="checkbox"/> Yes <input type="checkbox"/> No	Rheumatic fever <input type="checkbox"/> Yes <input type="checkbox"/> No
Mitral valve prolapse <input type="checkbox"/> Yes <input type="checkbox"/> No	Varicosities/ Phlebitis <input type="checkbox"/> Yes <input type="checkbox"/> No
DVT <input type="checkbox"/> Yes <input type="checkbox"/> No	Blood clot <input type="checkbox"/> Yes <input type="checkbox"/> No
Blood Disorders	
Blood transfusion received <input type="checkbox"/> Yes <input type="checkbox"/> No	Sickle cell anemia <input type="checkbox"/> Yes <input type="checkbox"/> No
Refuse blood transfusion <input type="checkbox"/> Yes <input type="checkbox"/> No	Thalassemia <input type="checkbox"/> Yes <input type="checkbox"/> No
Anemia <input type="checkbox"/> Yes <input type="checkbox"/> No	Clotting disorder <input type="checkbox"/> Yes <input type="checkbox"/> No
Rh incompatibility <input type="checkbox"/> Yes <input type="checkbox"/> No	
Breast History	
Breast cancer <input type="checkbox"/> Yes <input type="checkbox"/> No	
Nursing issue <input type="checkbox"/> Yes <input type="checkbox"/> No	
Genito-Urinary	
Frequent urinary tract infections (UTIs) <input type="checkbox"/> Yes <input type="checkbox"/> No	
Pyelonephritis <input type="checkbox"/> Yes <input type="checkbox"/> No	
Abnormal uterus <input type="checkbox"/> Yes <input type="checkbox"/> No	
Ectopic pregnancies <input type="checkbox"/> Yes <input type="checkbox"/> No	
Kidney disease <input type="checkbox"/> Yes <input type="checkbox"/> No	
Gastrointestinal (GI) System	
Liver disorder <input type="checkbox"/> Yes <input type="checkbox"/> No	
GI disorder <input type="checkbox"/> Yes <input type="checkbox"/> No	
Jaundice <input type="checkbox"/> Yes <input type="checkbox"/> No	
Rheumatoid Arthritis	
Rheumatoid arthritis <input type="checkbox"/> Yes <input type="checkbox"/> No	
Lupus <input type="checkbox"/> Yes <input type="checkbox"/> No	

Past Medical History — continued

If you do not know the answer to any of the following questions, please leave blank.

Infection

- | | | | | | |
|----------------|------------------------------|-----------------------------|------------------------|------------------------------|-----------------------------|
| HIV/AIDS | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Neonatal GBS | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Hepatitis B | <input type="checkbox"/> Yes | <input type="checkbox"/> No | MRSA | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Hepatitis C | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Genital warts | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Chlamydia | <input type="checkbox"/> Yes | <input type="checkbox"/> No | HPV | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Gonorrhea | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Abnormal pap | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Syphilis | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Varicella (chickenpox) | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Genital herpes | <input type="checkbox"/> Yes | <input type="checkbox"/> No | | | |

Other medical history:

Past Surgical History

If you do not know the answer to any of the following questions, please leave blank.

- | | | | | | |
|----------------------------------|------------------------------|-----------------------------|--|------------------------------|-----------------------------|
| Cesarean section | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Cervical laser ablation | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Conization | <input type="checkbox"/> Yes | <input type="checkbox"/> No | LEEP procedure | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Cervical cryocauterization | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Breast Augmentation/
Reconstruction | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Gynecological surgical procedure | <input type="checkbox"/> Yes | <input type="checkbox"/> No | | | |

Other surgical history:

Family History

If you don't know the answer to any of the following questions, please leave blank.

If you or the baby's father is adopted, fill out this section the best that you can.

Relationship	Thalassemia	Neural tube defect	Congenital heart defect	Down syndrome	Tay-Sachs	Sickle cell disease	Hemophilia	Muscular dystrophy	Cystic Fibrosis	Huntington's chorea	Mental retardation	Autism	Fragile X	Other inherited disorder	Metabolic disorder	Child with birth defects	Miscarriages (many)	Stillbirth	Other genetic risks
Mother																			
Father																			
Sister																			
Brother																			
Grandmother (mother's side)																			
Grandfather (mother's side)																			
Grandmother (father's side)																			
Grandfather (father's side)																			
Dad of baby																			
Dad's family																			
Daughter																			
Son																			
Aunt (mother's side)																			
Uncle (mother's side)																			

Family History — continued																				
If you don't know the answer to any of the following questions, please leave blank. If you or the baby's father is adopted, fill out this section the best that you can.																				
Relationship	Thalassemia	Neural tube defect	Congenital heart defect	Down syndrome	Tay-Sachs	Sickle cell disease	Hemophilia	Muscular dystrophy	Cystic Fibrosis	Huntington's chorea	Mental retardation	Autism	Fragile X	Other inherited disorder	Metabolic disorder	Child with birth defects	Miscarriages (many)	Stillbirth	Other genetic risks	
Aunt (father's side)																				
Uncle (father's side)																				
Other																				
Details:																				
Comments:																				
Social History														CLINIC USE ONLY						
Alcohol and Drug Use														In Epic: Social						
Do you drink alcohol? <input type="checkbox"/> Yes <input type="checkbox"/> No																				
If yes , how much do you usually drink in one week:																				
Do you use tobacco? <input type="checkbox"/> Yes <input type="checkbox"/> No																				
If yes , what type of tobacco do you use?																				
How long have you used tobacco?																				
Do you use other drugs? <input type="checkbox"/> Yes <input type="checkbox"/> No																				
Sexual Health														CLINIC USE ONLY						
Are you sexually active? <input type="checkbox"/> Yes <input type="checkbox"/> No														In Epic: Social						
If yes , what type of birth control do you use:																				