Women's
Integrated Healthcare, P.A.

PREGNANCY QUESTIONNAIRE

Name: _____ Date of Birth: _____

Is there a phone number where we can leave confidential messages such as test results/special instructions for today's visit as well as for future visits? If yes, phone number: _____ (mobile/home)

Marital Status: □ Single □ Partnered/Married □ Divorced □ Widowed □ Other
If you have a partner/spouse, what is his or her name? _____
Emergency Contact: _____ Phone Number: _____
Pediatrician's name: _____ Phone Number: _____

PAST OR CURRENT MEDICAL PROBLEMS					
(Please Check)	Yes	No	(Please Check)	Yes	No
Diabetes	□	□	Lung Problems, Asthma, Tuberculosis	□	□
High Blood Pressure	□	□	Breast Problems	□	□
Heart Disease	□	□	Rheumatoid Arthritis, Lupus	□	□
Autoimmune Disease	□	□	Urinary Incontinence	□	□
Kidney or Bladder Disease	□	□	Uterine Abnormalities	□	□
Neurologic Problem, Seizures	□	□	Migraines	□	□
Psychiatric Problems	□	□	Anxiety, Panic Attacks	□	□
Depression, Postpartum Depression	□	□	Herpes	□	□
Hepatitis, Liver Disease	□	□	Anemia, Blood Disorder	□	□
Trauma, Violence	□	□	Infertility	□	□
Thyroid Disorder	□	□	Allergies, Hay Fever, Chronic Sinusitis	□	□
Blood Transfusion	□	□	Sexually Transmitted Diseases	□	□
Chicken Pox	□	□	Abnormal Pap	□	□
Varicose Veins, Blood Clots in Veins	□	□	HIV	□	□

Other: _____

Details of positive responses_____
_____

MENSTRUAL HISTORY

Age at onset of mensus: _____ Cycle: _____ days (start to start) Usual duration: _____days
Flow: □ Light □ Medium □ Heavy Pain or Cramps? □ Yes □ No
LMP: _____ □ Definite □ Approximate (Month Known) □ Unknown

OBSTETRIC HISTORY

DATE (MONTH/YEAR)	GA WEEKS	LENGTH OF LABOR	BIRTH WEIGHT	SEX (M/F)	TYPE OF DELIVERY	ANES	PLACE OF DELIVERY	PRETERM LABOR (YES/NO)	COMMENTS/ COMPLICATIONS

INFECTION HISTORY

1. High Risk Hepatitis B Immunized?	□ Yes	□ No	4. Chlamydia/ or Gonorrhea?	□ Yes	□ No
2. Live with someone with TB or exposed to TB?	□ Yes	□ No	5. Patient or partner with Syphilis?	□ Yes	□ No
3. Patient or partner has history of genital herpes?	□ Yes	□ No	6. Patient or partner with AIDS/HIV?	□ Yes	□ No

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PRENATAL GENETIC SCREENING/TERATOLOGY COUNSELING *Includes Patient, Baby's Father, or anyone in either family with any one of the following disorders:*		
1. Will you be 35 years old or older when the baby is due?	□ Yes	□ No
2. Thalassemia?	□ Yes	□ No
3. Neural Tube Defect, Spina Bifida (Open Spine), Anencephaly?	□ Yes	□ No
4. Congenital Heart Defect?	□ Yes	□ No
5. Down Syndrome?	□ Yes	□ No
6. Tay-Sachs?	□ Yes	□ No
7. Canavan Disease?	□ Yes	□ No
8. Sickle Cell Disease or Trait?	□ Yes	□ No
9. Hemophilia or Blood Disorder?	□ Yes	□ No
10. Muscular Dystrophy?	□ Yes	□ No
11. Cystic Fibrosis?	□ Yes	□ No
12. Huntington's Chorea?	□ Yes	□ No
13. Mental Retardation/Autism? If yes, was the person tested for Fragile X? □ Yes □ No	□ Yes	□ No
14. Other Inherited Genetic or Chromosomal Disorder?	□ Yes	□ No
15. Maternal Metabolic Disorder (eg. Type 1 Diabetes, PKU)?	□ Yes	□ No
16. Patient or Baby's Father had a child with birth defects not listed above?	□ Yes	□ No
17. Recurrent Pregnancy Loss or a Stillbirth?	□ Yes	□ No
18. Medications/Street Drugs/Alcohol since last menstrual period? If yes, Agent(s)? _____	□ Yes	□ No
19. Any Other? _____	□ Yes	□ No

To the best of my knowledge, this information is complete and accurate.

_____

Printed Patient Name

_____

Patient Signature Date

Women's Integrated Healthcare, P.A.

Consent for Release of Information

I, _____, authorize Women's Integrated Healthcare, P.A. to release my medical information, including lab results to the following person(s):

_____

Name-Print Date of Birth Relationship to Patient

_____

Name-Print Date of Birth Relationship to Patient

Expiration Date of Authorization
This authorization will remain effective unless revoked or terminated by the patient OR the patient's personal representative.

Right to Terminate or Revoke Authorization
You may revoke or terminated this authorization by submitting a written revocation to Women's Integrated Healthcare, P.A. You should contact the HIPAA Compliance Officer to terminate the authorization.

- ☐ I DO authorize for medical information to be left via voicemail or answering machine.
- ☐ I DO NOT authorize for medical information to be left via voicemail or answering machine.

Acknowledgement of Receipt

By my signature below, I acknowledge that I have received the Women's Integrated Healthcare, P.A. *Notice of Privacy Practices* on or prior to ANY service being provided to me by Women's Integrated Healthcare, P.A. following September 10, 2015.

_____
Patient's Initials-I have received the HIPAA booklet.

_____
Name of Patient (Please Print)

_____
Signature of Patient Today's Date

_____
Signature of Patient's Representative Today's Date