Hunterdon Health

PRENATAL CARE PACKET Name:_____ DOB:_____

PERSONAL HEALTH HISTORY

1. Please check off any condition that you have now or have had in the past:

Heart disease ☐	Rheumatic fever/ heart murmur ☐	Headaches ☐
Mitral valve prolapse ☐	Asthma ☐	Hepatitis ☐
High blood pressure ☐	Tuberculosis ☐	Peptic Ulcer ☐
Blood disease ☐	Lung disease/difficulty breathing ☐	Hemorrhoids ☐
Thrombocytopenia/Rh sensitization ☐	Epilepsy ☐	Bowel Disease ☐
Anemia ☐	Depression ☐	Diabetes ☐
Sickle cell anemia ☐	Nervous or mental problems ☐	Thyroid disorder ☐
Blood clots ☐	Collagen disease or lupus ☐	Arthritis ☐
Frequent infections ☐	Bladder or kidney infections ☐	Pelvic infection ☐
Fibroids ☐	Mass or tumor of cervix or pelvis ☐	Molar pregnancy ☐
Herpes ☐	Chlamydia ☐	Gonorrhea ☐
Syphilis ☐	HIV ☐	

2. Have you had any major injuries or Surgeries? **Yes** _ **No** _

3. Are you having any health problems or symptoms now? **Yes** _ **No** _

4. Have you taken any prescription or non-prescription medicines since your last menstrual period? **Yes** _ **No** _

5. In the past few months, have you been near a person with the measles (rubella), or have you had a temperature of 103 degrees or higher? **Yes** _ **No** _

6. Do you have concerns that you may have contracted the Zika Virus? **Yes** _ **No** _ In the past few months have you traveled to an area endemic to Zika Virus? If so, Where? _____

7. Are you allergic to any medicines, foods, or have seasonal allergies? **Yes** _ **No** _

8. Is your period often irregular? How many days is your menstrual cycle? **Yes** _ **No** _

9. Have you ever had an abnormal Pap Smear? **Yes** _ **No** _ When? _____

10. Have you had a surgical Conization or cervical Cerclage? **Yes** _ **No** _

11. When was your last Pap Smear? _____

12. Have you used any birth control (contraceptive) methods this year? **Yes** _ **No** _

13. What type? _____ If you used an IUD, when was the IUD removed? _____ If you took birth control pills, did you have any side effects? **Yes** _ **No** _ When did you stop taking them? _____

14. Have you ever had problems getting pregnant? **Yes** _ **No** _

15. Have you ever been exposed to radiation, chemicals, or DES, or have you received X-rays during this pregnancy? **Yes** _ **No** _

16. Have you or the baby's father ever received a blood transfusion, taken intravenous drugs, had sex with a gay or bisexual man, or with a person who you suspected had HIV or AIDS? **Yes** _ **No** _

17. Do you smoke cigarettes? **Yes** _ **No** _ How many per day? _____

18. Do you drink wine, beer or alcohol? **Yes** _ **No** _ What type:_____ how much:_____ and how often: _____

19. Have you used any recreational" drugs (such as cocaine, marijuana, etc.) since your last period? **Yes** _ **No** _

Name: _____ **DOB:** _____

20. Did this pregnancy happen by surprise? **Yes** _ **No** _

21. Do you feel like you need more emotional support for this pregnancy? **Yes** _ **No** _

22. Do you feel a lot of stress in your life right now? **Yes** _ **No** _

23. Are you on any kind of diet? **Yes** _ **No** _

24. Do you have a private well? **Yes** _ **No** _ if so, has the water ever been tested? **Yes** _ **No** _

FAMILY HISTORY AND GENETIC SCREENING

25. Will you be 35 years or older when the baby is due? **Yes** _ **No** _

26. Are you and the baby's father related to each other by blood? **Yes** _ **No** _

27. Has the baby's father ever had any of the following Conditions?

- Hepatitis or yellow jaundice **Yes** _ **No** _
- Sexually transmitted disease (like gonorrhea, Chlamydia, etc.) **Yes** _ **No** _
- Herpes or recurrent genital itching, sores, or pain **Yes** _ **No** _
- HIV or AIDS **Yes** _ **No** _

28. In the past few months has the baby's father traveled to any state in the U.S with a concern for Zika Virus (ie: Florida, southern states) **Yes** _ **No** _ If so, Where?_____ Or traveled out of the U.S to an area endemic to Zika Virus? **Yes**_ **No**_

If so, Where? _____

29. Have you, the baby's father, or anyone in either of your families ever had any of the following Conditions?

- Down's Syndrome **Yes** _ **No** _
- Twins or triplets **Yes** _ **No** _
- Neural tube defect for example, anencephaly or spina bifida (meningomyelocele or open Spine) **Yes** _ **No** _
- Diabetes **Yes** _ **No** _
- Hypertension **Yes** _ **No** _
- Psychological or psychiatric problems **Yes** _ **No** _
- Huntington's chorea **Yes** _ **No** _
- Mental retardation **Yes** _ **No** _
- Hemophilia **Yes** _ **No** _
- Alcohol or Substance abuse **Yes** _ **No** _
- PKU **Yes** _ **No** _
- Cystic fibrosis **Yes** _ **No** _
- Muscular dystrophy **Yes** _ **No** _
- Birth defect **Yes** _ **No** _
- Other birth defect, familial disorder, or chromosomal abnormality **Yes** _ **No** _

30. In any previous relationships, have you or the baby's father had a child, born dead or alive, with a birth defect listed above?

Yes _ **No** _ If yes, what was the defect and who had it? _____

31. Have either of you had a chromosomal study? **Yes** _ **No** _

32. Please answer the following questions, based on the ancestry of you and the baby's father:

- Jewish - have either of you been screened for Tay-Sachs Disease? **Yes** _ **No** _
- Black or Afro-American - either of you Screened for sickle cell trait? **Yes** _ **No** _
- Italian, Greek or Mediterranean - either of you tested for Beta thalassemia? **Yes** _ **No** _
- Philippine or Southeast Asian - either of you tested for Beta thalassemia? **Yes** _ **No** _

If yes, please indicate who had the test and the results: _____

33. Do you think you are at increased risk of having a baby with a birth defect or genetic problem? **Yes** _ **No** _

34. Do you have any other questions or concerns about your health or about this pregnancy? **Yes** _ **No** _