



Pregnancy Health History

General Health

Age _____
 Will you be 35 or older at delivery? Yes No

Health conditions you are under a doctor's care for:

Previous surgery _____
 (This includes previous breast surgery, or augmentation)

Medication you currently take
 (both prescription and over the counter)

Allergies to medications _____
 Food _____
 Allergies _____

Reproductive Health

Number of Previous Pregnancies _____
 Number of miscarriages/termination _____
 Number of living children _____

Name	Year of birth	Gender	Birthweight	Medical Problems

Problems/complications with previous pregnancies _____

Problems/complications with this pregnancy _____

- Did you smoke during this pregnancy? Yes No
- Did you drink alcohol during pregnancy? Yes No
 If yes, how much? _____
- Have you used any recreational drugs during pregnancy? Yes No
 If yes, which and how often? _____
- Do you have any pets? Yes No
- Are you exposed to X-rays or radiation at work? Yes No
- If applicable, did you breastfeed your other child/children? Yes No
- If applicable, did any of your other newborns have problems with jaundice? Yes No
- If applicable, have you ever suffered from postpartum depression? Yes No

- Are there any children in your family who have died of Sudden Infant Death Syndrome (SIDS)? Yes No
- Are there any children in your family who have died of unexplained causes? Yes No

Results of prenatal testing

Your blood type _____

- If you have an Rh negative blood type, have you received a Rhogam injection? Yes No
- Do you have any sexually transmitted diseases? (Chlamydia, gonorrhea, syphilis) Yes No
- Are you a carrier for Hepatitis B? Yes No
- Do you have herpes? Yes No
- Are you HIV positive? Yes No
- Are you immune to rubella (German measles) and varicella (chickenpox)? Yes No
- Are you a carrier for Group B Strep? Yes No

Any special testing for inherited/genetic disorders (e.g. Tay Sachs, sickle cell disease, cystic fibrosis, muscular dystrophy)?

Any abnormal ultrasound results? _____

Any abnormal quad marker screen results? _____

Any abnormal Chorionic Villus Sampling (CVS) results? _____

Any abnormal amniocentesis results? _____

What describes your baby's ancestry (both birth mother and father)? Circle all that apply.

- Caucasian? Yes
- Mediterranean (Greek, Italian, Middle Eastern)? Yes
- African American? Yes
- Hispanic? Yes
- Eastern European Jewish? Yes
- Cajun, French Canadian? Yes
- Puerto Rican, Caribbean, Central American? Yes
- Southeast Asian? Yes