GRANDE DUNES OBGYN & FACIAL AESTHETICS
1021 CIPRIANA DR. SUITE 250
MYRTLE BEACH, SC 29572
TEL 843.839.2229 FAX 843.839.2230

Prenatal Questionnaire

Name: _____ DOB: _____ Date: _____

Race: ___ Caucasian ___ Black ___ Latin ___ Asian ___Other:_____

Marital Status: ___Married ___Single ___Separated ___Divorced ___Widowed

Father of Baby: _____ _____Age: _____Race:_____

Are you employed? ___Yes ___No If YES, who is your Employer? _____

Primary Language: _____

Menstrual History

What was the first day of your last menstrual period? _____/_____/_____

Do you have regular monthly periods? ___Yes ___No

Were you on birth control when you got pregnant? ___Yes ___No

Have you had any significant Nausea? ___Yes ___No Vomiting? ___Yes ___No

Any other symptoms you are concerned about since your positive pregnancy test? _____

_____

Past Pregnancies

How many times have you been pregnant? _____ How many full term deliveries have you had? _____

How many premature deliveries (before 37weeks) have you had? _____ How many miscarriages? _____

How many abortions have you had? _____ Have you ever had an ectopic pregnancy? _____

Have you ever had twins or triplets? _____ How many living children do you have? _____

Have you had recurrent miscarriages? _____ Or ever had a stillbirth? _____

Past Pregnancies

Year of Birth	How many weeks pregnant?	Birth Wt	M/F	Vaginal/ C-section	Premature Labor?	Place of Delivery	Any problems with delivery or baby?

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Prenatal Questionnaire Continued

Medical History

Do you have a history of any of the following medical problems?

Diabetes	Y	N
Hypertension	Y	N
Heart Disease	Y	N
Autoimmune Disease	Y	N
Kidney Disease	Y	N
Frequent Urinary tract Infections	Y	N
Seizures/Epilepsy	Y	N
Migraine Headaches	Y	N
Psychiatric Disorders	Y	N
Depression	Y	N
Hepatitis/Liver disease	Y	N
Blood Clots in Legs or Lungs	Y	N
Thyroid Disease	Y	N
Lung Disease/Asthma	Y	N
Seasonal Allergies	Y	N
Breast problems	Y	N
Uterine Fibroids/abnormalities	Y	N
Ovarian Cysts	Y	N
Polycystic Ovarian Syndrome	Y	N
Hx of ABNORMAL pap smear	Y	N

If you answered YES to any of the above, please give details: _____

_____

Please list any prescription or over the counter medications you have taken since your last menstrual period:

_____

Allergies to medication?_____

LATEX ALLERGIC? Y N

Please list any surgeries in the past with dates:

_____

_____

Have you had any problems with anesthesia in the past? Y N

If YES, please give details: _____

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Prenatal Questionnaire Continued

Have you ever received a blood transfusion? Y N When:_____

Are you a cigarette smoker? Y N How much per day? _____ How many years of use? _____

Do you drink alcohol? Y N How often do you drink? _____

Do you use any illicit drugs? Y N If yes, which ones?_____

Do you have any problems with violence or abuse at home? Y N

Your Family Medical History

Has anyone in your family been diagnosed with the following medical problems (grandparents, parents, children, siblings)?

Diabetes	Y	N
Heart Disease	Y	N
Stroke/Blood Clots	Y	N
Hypertension	Y	N
Cancer-breast, uterine, ovarian, colon	Y	N
Autoimmune Disease	Y	N
Thyroid Disorder	Y	N

Genetic History

Has anyone in your family or the father of the baby's family ever been diagnosed with the following?

Anemia /Blood Disorders	Y	N
Italian, Greek, Mediterranean descent	Y	N
Jewish, French Canadian, Cajun	Y	N
Tay-Sachs	Y	N
Spina Bifida	Y	N
Canavan's Disease	Y	N
Sickle Cell Anemia/Trait	Y	N
Hemophilia	Y	N
Muscular Dystrophy	Y	N
Cystic Fibrosis	Y	N
Huntington's Chorea	Y	N
Mental Retardation/Autism	Y	N
Fragile X Syndrome	Y	N
Inherited or Chromosomal Disorders	Y	N

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Prenatal Questionnaire Continued

Genetic History Continued

Metabolic Disorders(PKU)	Y	N
Cleft Lip/Palate	Y	N
Deafness or Blindness at birth	Y	N
Birth Defects	Y	N

Will you be **35 or older** when you deliver? Y N

History of Infections

Have you ever been diagnosed with any of the following sexually transmitted infections?

___ Chlamydia	___Hepatitis B	___Syphilis
___Gonorrhea	___Hepatitis C	___Genital Warts
___Trichimonas	___HIV	___Herpes (you or your partner)

Have you ever been exposed to Tuberculosis or ever had a positive TB test? Y N

Have you had chicken pox? Y N

Do you have cats in your home? Y N

Do you have a history of **MRSA** infection within the last 3 years? Y N

Summary

Do you have any additional information you would like to share or any questions for your provider?

_____

_____

_____

_____

_____

Are you considering adopting out? Y N

Please Provide Pharmacy you would like prescriptions escribed to:_____