



New Patient Health Questionnaire

We welcome the opportunity to care for you and your baby. The following questions will aid us in completing your initial evaluation and should be completed before you meet with the doctor. These intake questions will also allow you the opportunity to review your personal and family history so that we can provide you with the best possible care.

Patient Name: _____ Date: _____

Date of Birth: _____ Age: _____ Allergies: _____ NONE

Reason for the visit: _____

Referring physician: _____

Occupation: _____ Marital Status: Married Single Divorced Widowed Other: _____

Pre-Pregnancy Weight: _____ Current Weight: _____ Height: _____

Date of last menstrual period: _____ Estimated Due Date: _____

About your pregnancy THIS pregnancy:

Conception: Spontaneous Ovulation induction hormones Insemination IVF Other Number of babies: _____

For IVF pregnancies only: ICSI Donor sperm Donor eggs (age of donor _____, ethnicity of donor _____)

About your symptoms & diagnostic tests during THIS pregnancy:

Table with columns for symptoms (Vaginal bleeding, Pelvic pressure, etc.) and diagnostic tests (Previous ultrasounds, Genetic testing, etc.), with Y/N checkboxes and a section for detail abnormalities.

About ALL of your pregnancies: (including your current pregnancy):

Summary table for all pregnancies with columns: Total Pregnancies, Full Term (37-42 wks), Premature (20-36 wks), Miscarriage (13-19 wks), Miscarriage (< 13 weeks), Abortions (D&C / D&E), Ectopic Pregnancies, Multiple Births, Living Children.

Information about our PAST pregnancies:					
	Y	N		Y	N
Vaginal deliveries: total #: []			Baby born with a birth defect:		
Cesarean sections: total #: []			Baby has(d) serious illness:		
Vacuum or forceps delivery:			Injury to uterus or cervix:		
Shoulder dystocia:			Heavy bleeding:		
Babies larger than 8 lb 12oz:			Blood transfusions:		
Babies smaller than 5 lb 9 oz:			Gestational diabetes:[] diet:[] insulin		
Still birth:			High blood pressure:		
Baby died within the 1 st year of life:			Preeclampsia/toxemia/HELLP:		
Detail any other complications in past pregnancies not mentioned above:					

Detail Positive remarks or Findings of significance: (e.g. Reason for cesarean section, type of baby abnormality, etc)

About your Medical, Surgical, and Gynecologic History:

	Y	N		Y	N
Obesity, weight > 185 pounds:			Diabetes mellitus		
Thyroid disease			Anemia, Sickle cell, Thalassemia, or other		
Hypertension			Low platelets or ITP		
Heart disease, murmur or arrhythmia			Kidney/urinary infection, stones, or other disease:		
Blood clot in your leg, lung or other			Inflammatory bowel disease		
Asthma or other lung disease			Epilepsy or other neurologic disorder		
Gallbladder stones or pancreatitis			Infertility		
Hepatitis or other liver disease			Cancer of any kind		
Lupus or other connective tissue disease			Cervical cone or LEEP for abnormal PAP smear		
Antiphospholipid syndrome			Uterine or cervical anomaly, tumors, or surgery		

Detail Positive remarks and list any other related medical problems or surgeries performed:

Current Medications: (including Prenatal vitamins, omega-3-fatty acids, supplements & nonprescription medications) _____

About your exposure to Medications/ Drugs during THIS pregnancy:

	Y	N		Y	N
Prozac, Zoloft, Paxil or other SSRI's:			Anxiety medication (Valium, Xanax):		
Seizure Medications:			Narcotics (Codeine or Vicodin):		
Antibiotic, antifungal, antiparasitic:			Alcohol:		
Environmental toxins:			Tobacco:		
Occupational hazards:			Amphetamine, Heroine, or Cocaine:		
X-Ray exposure:			Herbal preparations:		

Detail positive remarks:

About your Family History (Significant other, Parents, Grandparents, Uncles, Aunts, Cousins, and Siblings):

	Y	N		Y	N
Heart defect at birth: hole in the heart			Thrombosis, DVT, blood clot or stroke		
Autism or mental retardation			Blood disorders: sickle cell, hemophilia		
Down Syndrome			Skeletal disorders: dwarfism, extra fingers		
Other genetic syndromes / diseases			Other:		

Detail Positive remarks and List any other relevant conditions:

Your and the Father of baby's Ethnicity: (circle ALL countries that apply)

	You or Egg donor		Father of baby	
	Y	N	Y	N
Caucasian				
Jewish, French Canadian or Cajun				
African American, African Descent, Puerto Rican, Caribbean, Central American or Black				
Italian, Greek, Middle Eastern, Spanish or Portuguese				
Chinese, Asian Indian, Pakistani, Taiwanese, Filipino, Korean or Southeast Asian				
Other ethnicity or countries of origin (Specify):				

Patient's signature: _____

Date: _____

Reviewed by : _____