



New Patient Questionnaire

Legacy Medical Group, Maternal-Fetal Medicine

Pregnancy History

Please list all of your previous pregnancies on the chart below:

Date	Weeks pregnant	Name	Birth weight	Hours of Labor	Anesthesia	Type of Delivery	Sex	Hospital	Complications

Medical History

Have you ever had any of the following problems:

	No	Yes
Previous C-section		
Gastrointestinal		
Varicella		
Thyroid disease		
Thromboembolic		
Uterine Anomaly		
Chlamydia		
Eating disorder		
Cardiovascular		
Urinary		
Blood transfusion		
Anemia		
Seizures		
Abnormal Pap		
Gonococcus		
Abuse		
Respiratory		
Infections		
Diabetes mellitus		
Blood disease		
Infertility		
Genital warts		
Herpes		
Other medical problems		

Surgical History

Have you had any of the following surgeries:

	No	Yes
C-section		
Abdomen surgery		
Uterine surgery		
Breast surgery		
Cervix surgery		
Other surgery		

Family History

	Breast Cancer	Colon Cancer	Diabetes	Eclampsia	High blood pressure	Ovarian Cancer	Preterm Labor	Miscarriage	Stroke	Other
Paternal grandfather										
Paternal grandmother										
Maternal grandfather										
Maternal grandmother										
Father										
Mother										
Brother										
Sister										
Other:										
Other:										

Substance History

Alcohol use

Have you used alcohol during the pregnancy?

Yes

Glasses of wine

Cans of beer

Shots of liquor

Drinks containing 0.5oz of alcohol

No

Drug use

Have you used street drugs during the pregnancy?

Yes

Marijuana (times per week)

Methamphetamines

Cocaine

IV drugs

No

Tobacco use

Number of years smoked

Number of packs per day

Quit: date _____

Have you used smokeless tobacco?

yes

no

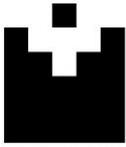
Social History

	Yes	No
Are you married?		
Are you partnered?		
Was this a planned pregnancy?		
Are you sexually active?		
Have you finished high school?		
Do you have a Bachelor's degree?		
Have you studied beyond a Bachelor degree?		

Social Lifestyle

	yes	no
Do you feel safe at home?		
Since your pregnancy began, have you been physically abused?		
Do you have current thoughts of harming yourself or others?		
Are there guns in your home?		
Do you exercise regularly?		
Are there any pets in the home?		
Caffeine		
Do you feel safe at work?		
History of sexual abuse or traumatic experience(s)?		
Do you have a current plan to harm yourself or others?		
Do you regularly use seat belts?		
Are there working smoke alarms in your home?		
Has your appetite/food intake changed with pregnancy?		

Do you have any allergies to medications? If so, list:
Meds currently taking:
Office Use: HT:Pre-pregnancy WT:
Current pharmacy/location:



OB Genetics Screening Questionnaire

LEGACY Legacy Medical Group Maternal-Fetal Medicine

HEALTH *These questions pertain to you, the baby's father, and anyone in either family.*

	You (or family)		Father of Baby (or family)	
	yes	no	yes	no
1. Will you be age 35 or older on your due date?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Thalassemia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Neural tube defect (e.g. spina bifida, anencephaly, myelomeningocele)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. Congenital heart defect	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. Down syndrome or other chromosome abnormality	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6. Tay-Sachs disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7. Canavan disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8. Familial Dysautonomia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9. Sickle cell disease or trait	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10. Hemophilia or other blood/bleeding disorders	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
11. Muscular dystrophy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
12. Cystic fibrosis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
13. Huntington's chorea	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
14. Mental retardation/autism or Fragile X syndrome	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
15. Other inherited or chromosomal disorder	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
16. Maternal metabolic disorder (e.g PKU, type I diabetes)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
17. Birth defect not listed above	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
18. Recurrent pregnancy loss or a stillbirth	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
19. Medications (including supplements, vitamins, herbs or over-the-counter drugs)/illicit/recreational drugs/alcohol since last menstrual period	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
20. Any other heritable condition	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>