LEGACY HEALTH

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	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 ☐ No

- ☐ Glasses of wine
- ☐ Cans of beer
- ☐ Shots of liquor
- ☐ Drinks containing 0.5oz of alcohol

Drug use

Have you used street drugs during the pregnancy?

☐ Yes ☐ No

- ☐ Marijuana (times per week)
- ☐ Methamphetamines
- ☐ Cocaine
- ☐ IV drugs

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 HEALTH **Legacy Medical Group Maternal-Fetal Medicine**

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?				
2. Thalassemia				
3. Neural tube defect (e.g. spina bifida, anencephaly, myelomeningocele)				
4. Congenital heart defect				
5. Down syndrome or other chromosome abnormality				
6. Tay-Sachs disease				
7. Canavan disease				
8. Familial Dysautonomia				
9. Sickle cell disease or trait				
10. Hemophilia or other blood/bleeding disorders				
11. Muscular dystrophy				
12. Cystic fibrosis				
13. Huntington's chorea				
14. Mental retardation/autism or Fragile X syndrome				
15. Other inherited or chromosomal disorder				
16. Maternal metabolic disorder (e.g PKU, type I diabetes)				
17. Birth defect not listed above				
18. Recurrent pregnancy loss or a stillbirth				
19. Medications (including supplements, vitamins, herbs or over-the-counter drugs)/illicit/recreational drugs/alcohol since last menstrual period				
20. Any other heritable condition				