

Patient Name: _____

Date of Birth _____

Having a healthy baby is a special event. Once a baby is born, families take certain precautions to ensure the baby's health and safety. The unborn child deserves similar care.

The following questions will help in the care of your pregnancy. Please answer these questions as well as you can. All answers will remain private. If you need help answering the questions, please ask your nurse or doctor. The first question relates to your family history. The next eight questions will be about you, your baby's father and both of your families. When thinking about your families, please include your child (or unborn baby), mother, father, sisters, brothers, grandparents, aunts, uncles, nieces, nephews or cousins.

1.	YES	NO	Will you be 35 years or older when the baby is due? Your age when baby is due:		
2.	YES	NO	Are you and the baby's father related to each other (i.e., cousins)?		
3.	YES	NO	Have you had three or more pregnancies that ended in miscarriages?		
Mother of Baby Father of Baby					
4.	YES	NO	YES	NO	Have you or the baby's father had a stillborn baby or a baby who died around the time of delivery?
5.	YES	NO	YES	NO	Do you or the baby's father have a birth defect or genetic condition such as a baby born with an open spine (spina bifida), a heart defect, or Down's Syndrome?
6.	YES	NO	YES	NO	Does anyone in your family or anyone in the baby's father's family have a birth defect or condition that has been diagnosed as genetic or inherited, such as open spine (spina bifida), a heart defect, or Down's Syndrome?
7.	YES	NO	YES	NO	Where your ancestors came from may sometimes give us important information about the health of your baby. Are you or the baby's father from any of the following ethnic/racial groups: Jewish, Black, Asian, Mediterranean (Greek, Italian)?
8.	YES	NO	YES	NO	Have you or the baby's father ever been screened to see if you are carriers of the gene for any of the following? Tay-Sachs Sickle Cell Thalassemia
Sometimes, the unborn baby can be exposed to outside factors that can cause birth defects. The next eight questions will give us important information about possible exposure to the baby.					
9.	YES	NO	Have you had any x-rays during this pregnancy?		
10.	YES	NO	Have you had any alcohol during this pregnancy?		
11.	Prior to your pregnancy, how often did you drink alcoholic beverages?				
	<input type="checkbox"/> Every day	<input type="checkbox"/> At least once a week, not daily	<input type="checkbox"/> At least once a month, not weekly	<input type="checkbox"/> Less than once a month	
				<input type="checkbox"/> I do not drink alcoholic beverages	
12.	Prior to your pregnancy, about how many alcoholic beverages did you usually have per occasion (1=one can of beer, one wine cooler, one glass of wine, or one shot of liquor)				
	<input type="checkbox"/> 3 or more	<input type="checkbox"/> 1 to 2	<input type="checkbox"/> I do not drink alcoholic beverages		
13.	YES	NO	Have you taken any over-the-counter, supplements, prescription or "street" drugs during this pregnancy? If yes, please list drugs.		
14.	YES	NO	Have you ever sought and/or received treatment for alcohol or drug problems? If yes, how long ago?		
15.	YES	NO	Do you think you are at increased risk of having a baby with a birth defect or genetic disorder?		
16.	YES	NO	At any time during the first two months of your pregnancy, have you had a rash or a fever of 103 F or higher?		

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A test for HIV is strongly recommended for all pregnant women, regardless of your responses to the next questions. The test is voluntary. There are two reasons to be tested: (1) New medications are available to reduce the chance of an infected mother passing HIV to her baby; and (2) Most women do not know they are infected with HIV until later in the disease. Sometimes, other infections can put you and your baby at risk. The following questions will help your doctor determine other areas for counseling and education.

17. YES NO Have you or your sexual partners ever had a sexually transmitted disease (STD or VD) such as chlamydia, gonorrhea, syphilis or herpes?

18. YES NO Have you ever had a serious pelvic infection or pelvic inflammatory disease (PID)?

19. YES NO Do you think any of your male sexual partners ever had sex with other men?

20. YES NO Have you or your sexual partners ever used IV street drugs?

21. YES NO Have you had sex with two or more partners in the last twelve months?

22. YES NO Do you think any of your sexual partners may have HIV or AIDS?

23. YES NO Have you or your sexual partners ever had a blood transfusion?

How safe you feel in your daily living gives us important information about risks to you and your baby. Please answer these questions as well as you can. All answers will remain private.

24. Do you feel safe.....
 YES NO In your personal relationship?
 YES NO Within your home?
 YES NO In your own neighborhood?
 YES NO Other (specify) _____

25. YES NO Have you ever had your feelings repeatedly hurt, been repeatedly put down, or experienced other kinds of hurting?

26. YES NO Are you being, or have you ever been hit, slapped, kicked, pushed or otherwise physically hurt? If yes, by whom?
 Husband Family Member
 Ex-husband Stranger
 Partner Other (specify) _____

27. YES NO Are you experiencing or have you ever-experienced uncomfortable touching or forced sexual contact? If yes, by whom?
 Husband Family Member
 Ex-husband Stranger
 Partner Other (specify) _____