JAN RYDFORS MD FACOG, ARON SCHUFTAN MD FACOG
401 Warren Street, Suite # 300, Redwood City, CA 94063
650.701.1882
www.rwcdocs.com

Please complete and bring this questionnaire with you to your first prenatal visit.

MEDICAL ALLERGIES

Which drugs or medicines are you allergic or sensitive to?

Drug	Reaction

PATIENT INFORMATION

Name:_____

Address:_____

Phone: Day (___) ____- _____ Evening (___) ____- _____ Cell (___) ____- _____

Age: ____ Date of Birth: _____

Marital Status: ☐ Married ☐ Single ☐ Widowed ☐ Divorced ☐ Separated

Ethnic Group/Race: _____ Religion: _____

Occupation: _____ Yrs of Education: _____

Emergency Contact: _____ Relationship: _____ Phone: (___) ____- _____

SPOUSE/SIGNIFICANT OTHER INFORMATION

Name of Spouse/Significant Other: _____

Is this the father of your baby? ☐ Yes ☐ No Age: _____

Phone numbers: Day (___) ____- _____ Evening (___) ____- _____ Cell (___) ____- _____

Ethnic Group/Race: _____ Religion: _____

Occupation: _____ Yrs of Education: _____

MENSTRUAL HISTORY/DATING INFORMATION

Date of the first day of your last period: _____ ☐ Definite ☐ Approximate ☐ Unknown

Was your period normal in number of days of flow? ☐ Yes ☐ No

Normal cycle length: _____ days

Date of conception, if known: _____

Where you on birth control pills/Depo shots when your last period started? ☐ Yes ☐ No

If so, when did you last take them/it: _____

Were you breastfeeding when your last period started? ☐ Yes ☐ No Date stopped: _____

Have your had a positive pregnancy test? ☐ Yes ☐ No Date: _____

If yes, was it done at: ☐ home ☐ clinic

PREVIOUS PREGNANCIES (List all previous pregnancies, include miscarriages or abortions):

	Month & Year	Vaginal delivery, cesarean, miscarriage or abortion?	Gestational age (wks at delivery)	Hours in labor	Baby's birth weight	Baby's name & sex	Epidural?	Name of hospital
1								
2								
3								
4								
5								
6								

Problems during pregnancy? _____

_____

Problems with labor or in postpartum? _____

_____

Any gestational diabetes during your pregnancies? ☐ Yes ☐ No

If yes, explain: _____

PAST MEDICAL/SURGICAL HISTORY
Have you ever had (If yes, please explain and note date):

YES **NO**

☐ ☐ Diabetes (high blood sugar)?

_____

☐ ☐ Hypertension (high blood pressure)?

_____

☐ ☐ Heart disease/congenital heart disease/defects, mitral valve prolapse or rheumatic fever?

_____

☐ ☐ Autoimmune disease such a s lupus or rheumatoid arthritis?

_____

YES	NO	
☐	☐	Kidney disease, kidney infection, urinary tract or many bladder infections?
☐	☐	Migraine headaches, Strokes or seizures?
☐	☐	Any other neurological problems?
☐	☐	Have you ever required psychiatric care?
☐	☐	Have you ever had hepatitis, liver disease or jaundice?
☐	☐	Have you ever had varicose veins or hemorrhoids?
☐	☐	Have you ever been treated for blood clots in your veins, deep venous thrombosis, inflammation in the veins, thrombosis, phlebitis or pulmonary embolism? If yes, please state which and when: _____
☐	☐	Have you had excessive bleeding after surgery or dental work?
☐	☐	Do you bleed more than other women do after a cut or a scratch?
☐	☐	Do you have a history of anemia?
☐	☐	Have you ever had a thyroid problems or taken thyroid medications?
☐	☐	In the last year, has anyone forced you to have sex when you did not want to? If yes, who? _____
☐	☐	In the last year, has anyone hit, slapped, kicked or otherwise hurt you? If yes, who? _____
☐	☐	Have you ever been in a major accident or suffered serious injuries or broken bones?

YES	NO		
☐	☐	Have your ever received a blood transfusion?	
☐	☐	Do you have a religious or other reason you would refuse a "life-saving" blood transfusion?	
☐	☐	Have you ever developed abnormal antibodies in your blood? If yes, has this caused a problem with a previous pregnancy & if so pls explain?	
☐	☐	Have you ever had asthma or tuberculosis?	

ALCOHOL/TOBACCO/DRUGS
Have you ever used any of the following:

YES	NO		
☐	☐	Tobacco/Cigarettes?	If yes, how much and when:
☐	☐	Alcohol, beer, wine?	If yes, how much and when:
☐	☐	Street drugs?	If yes, which ones, how much and when:
☐	☐	Does anyone in your household smoke?	If yes, who:
☐	☐	Does your partner abuse alcohol or drugs?	

GYN HISTORY
Have you ever had any gynecological surgical procedure such as:

YES	NO		
☐	☐	Cervical Conization	If yes, when and where:
☐	☐	Leep Procedure	If yes, when and where:
☐	☐	Laser treatment	If yes, when and where:
☐	☐	Cryosurgery of the cervix	If yes, when and where:
☐	☐	Dilation and curettage (D&C)	If yes, when and where:
☐	☐	Have you ever had any other surgical procedures?	
☐	☐	Have you ever had any breast problems?	
☐	☐	Have our ever had any problems with breastfeeding?	
☐	☐	Have you ever been hospitalized for a non-surgical reason other than a normal delivery?	
☐	☐	Have you ever had any complications or problems from anesthesia?	
☐	☐	Have you ever had an abnormal PAP smear?	
☐	☐	Do you or anyone in your family have a history of an abnormal uterus?	

YES	NO	
☐	☐	Did your mother take DES or any other hormones when she was pregnant with you to prevent miscarriage? _____
☐	☐	Did it take more than one year to become pregnant? _____
☐	☐	Have you ever been evaluated or treated for infertility?_____
☐	☐	Is there a history of medical problems in your family that you feel might adversely affect your health or this pregnancy? _____
☐	☐	Do you have any other problem we have not asked about which you feel might be of importance to this pregnancy? If yes, what?_____
☐	☐	Have you had any symptoms or problems since your last menstrual period?

_____

GENETIC HISTORY

Will you be age 35 or older at delivery? ☐ yes ☐ no

Have you had three or more miscarriages or a prior stillbirth? ☐ yes ☐ no

Used any medications, alcohol or drugs since your pregnancy? ☐ yes ☐ no

Is your blood type Rh negative? ☐ yes ☐ no ☐ not sure

Are you or the baby's father of Mediterranean ancestry? ☐ yes ☐ no
If yes, has either of you been screened for Thalassemia? ☐ yes ☐ no
If yes, please indicate who was screened and the results: _____

Are you or the father of the baby of Jewish, Cajun or French Canadian descent? ☐ yes ☐ no
If yes, has either of you been screened for Tay-Sachs and/or Canavan's disease? ☐ yes ☐ no
If yes, indicate who was screened and the results: _____

Are you or the father of the baby of African American ancestry? ☐ yes ☐ no
If yes, has either of you been screened for sickle cell disease or trait? ☐ yes ☐ no
If yes, indicated who was screened and the results: _____

Have you, the baby's father or anyone in either family had one of the following? If yes, please indicate who:

YES	NO	
☐	☐	Brain, spinal cord or neural tube defects, meningomyelocel (open spine), spina bifida or anencephaly?

_____

☐	☐	Congenital heart disease/defect? _____
☐	☐	Down Syndrome? _____
☐	☐	Hemophilia (blood that does not clot well) or any other inherited blood clotting disease? _____
☐	☐	Muscular Dystrophy, Huntington's Chorea, or Cystic Fibrosis: _____
☐	☐	Mental retardation or autism? _____ If YES, was the person tested for fragile X? _____

YES	NO	
☐	☐	Other inherited genetic or chromosomal disorders? Please identify: _____
☐	☐	Insulin dependent diabetes, phenylketonuria or any other metabolic disorder? _____
☐	☐	A prior child with a birth defect not listed above?

INFECTION HISTORY

YES	NO	
☐	☐	Have your ever received BCG (a shot to prevent TB—not given routinely in the US)?
☐	☐	Have you ever had a positive skin test for Tuberculosis (TB)?
☐	☐	Do you live with someone who has had TB?
☐	☐	Have you been otherwise exposed to TB?
☐	☐	Do you have genital herpes?
☐	☐	Does your partner have genital herpes?
☐	☐	Have you had a rash or a viral illness since your last period?
☐	☐	Have you ever had gonorrhea, Chlamydia, Syphilis, Trichomoniasis,or any other STD's?
☐	☐	If known, are you a Group B Streptococcus carrier?
☐	☐	Have you ever had chickenpox/varicella?
☐	☐	Have you ever been vaccinated against chickenpox?
☐	☐	Have you ever had any other infectious diseases that could affect this pregnancy?
☐	☐	Do you have any cats at home?