Phuong T. Nguyen, MD, FACOG
Obstetrics & Gynecology

PRENATAL MEDICAL QUESTIONNAIRE

Name: _____ Date of Birth: _____

1. Your age: _____ Baby's Father's age: _____
2. Number of pregnancies you have had: _____

Full term: _____ Premature _____ Miscarriages: _____ Abortions: _____ Ectopics: _____

3. Have you, the baby's father, or anyone in either of your families ever had any of the following disorders?

Down's Syndrome	Yes ___ No ___
Other chromosomal abnormality	Yes ___ No ___
Neural tube defect, i.e., spina bifida, anencephaly	Yes ___ No ___
Hemophila	Yes ___ No ___
Muscular dystrophy	Yes ___ No ___
Cystic Fibrosis	Yes ___ No ___

4. Do you or the baby's father have a birth defect? Yes ___ No ___
   If yes, who had the defect and what is it? _____
5. In any previous marriage, have you or the baby's father had a child, born dead or alive, with a birth defect not listed in question #2 above? Yes ___ No ___
   If yes, what was the defect and who had it? _____
6. Do you or the baby's father have any close relatives with mental retardation? Yes ___ No ___
   If yes, indicate the relationship to you or to the baby's father: _____
   Indicate the cause, if known: _____
7. Do you, the baby's father, or a close relative in either of your families have birth defect, any familial disorder, or a chromosomal abnormality not listed above? Yes ___ No ___
   If yes, indicate the condition and the relationship of the affected person to you or to the baby's father:
   _____
8. In any previous marriage, have you or the baby's father had a stillborn child or three or more first-trimester spontaneous pregnancy losses? Yes ___ No ___
   If yes, have either of you had a chromosomal study? Yes ___ No ___
   If yes, indicate who and the results: _____
9. If you or the baby's father are of Jewish ancestry, have either of you been screened for Tay-Sachs disease? Yes ___ No ___Not applicable ___
   If yes, indicate who and the results: _____
10. If you or the baby's father are Black, have either of you been screened for sickle cell trait? Yes ___ No ___Not applicable ___
    If yes, indicate who and the results: _____
11. If you or the baby's father are of Italian, Greek, or Mediterranean background, have either of you been tested for B-thalassemia? Yes ___ No ___Not applicable ___
    If yes, indicate who and the results: _____

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12. If you or the baby's father are of Philipine or Southeast Asian ancestry, have either of you been tested for A-thalassemia Yes ___ No ___Not applicable ___
    If yes, indicate who and the results: _____
13. Excluding iron and vitamins, have you taken any medications or recreational drugs since being pregnant or since your last menstrual period (include non-prescription drugs)? Yes ___ No ___
    If yes, give name of medication and time taken during pregnancy: _____
14. Are you immune to Rubella (3 day measles) or have you received the vaccination? Yes ___ No ___
15. Is there a family history of twins or triplets? Yes ___ No ___
    If so, who had them? _____
16. Do you or your husband have a history of:
    - Genital herpes Yes ___ No ___
    - Genital warts Yes ___ No ___
    - Gonorrhea Yes ___ No ___
    - Chlamydia Yes ___ No ___
    - Syphilis Yes ___ No ___
    - HIV (AIDS) Yes ___ No ___
17. Do you smoke? Yes ___ No ___ If so, how much? _____
18. Do you drink alcohol? Yes ___ No ___ If so, how much? _____
19. Do you have a cat? Yes ___ No ___
20. HIV (AIDS) testing is a routine part of our lab prenatal profile blood work. If you do not wish to be tested, you must sign a request for such prior to your labs being done.
21. Prenatal screening can help detect some birth defects such as Down's syndrome, trisomy 18 & 13, neural tube defects, abdominal wall defects, and Smith-Lemli-Opitz syndrome. There are 3 types of screening tests:
    - **Quad Marker screening**: one blood specimen drawn at second trimester (15-20 weeks) of pregnancy.
    - **Serum Sequential Screening**: combines first trimester (10-13.6 weeks of pregnancy) blood test results with second trimester (15-20 weeks) blood test results.
    - **Sequential Integrated Screening**: combines Nuchal Translucency (using ultrasound to measure the amount of fluid behind the neck of the fetus at 11–13.6 weeks of pregnancy) with first and second trimester blood test results.

    Do you desire this screening test? Yes ___ No ___ (Please circle the type of screening test above).

Patient's Signature _____ Date _____