Prenatal Registration and Obstetrical Questionnaire

Date______________________

Name	Rank	Age	Occupation	Work Phone	Ethnic Origin ☐ Caucasian ☐ Hispanic ☐ Asian ☐ Black ☐ American Indian ☐ Indian ☐ European ☐ Other
Home Address	Home Phone	Work Address			

Sponsor's Name	Sponsor's Rank	Age	Occupation	Work Phone	Ethnic Origin ☐ Caucasian ☐ Hispanic ☐ Asian ☐ Black ☐ American Indian ☐ Indian ☐ European ☐ Other
Sponsor's Home Address	Sponsor's Home Phone	Sponsor's Work Address			

What was the first day of your last menstrual period? _______________

Was the period: ☐ NORMAL or ☐ ABNORMAL?
Are you: ☐ CERTAIN or ☐ UNCERTAIN of this date?

How old were you when you had your first period? _________________

Are your periods normally: ☐ REGULAR or ☐ IRREGULAR?

How often do you usually get your period? Every _________ days.
For how long do you usually flow? For ___________ days.

Pain or cramps with your period? ☐ YES ☐ NO ☐ SOMETIMES.

______How many times have you been pregnant?
______How many live births?
______How many miscarriages or abortions?
______How many children are at home?

Describe the last form of birth control you used before pregnancy, and when you stopped it.

If you used birth control pills in the past, when did you stop taking them? _____________

Normal Weight ________ Height ________

Weight just before pregnancy ________

Please list all past pregnancies.

PREGNANCY NUMBER	DATE	WEEKS PREGNANT	VAGINAL OR C-SECTION	LENGTH OF LABOR	ANESTHESIA	HOSPITAL	SEX OF BABY	WEIGHT OF BABY	COMPLICATIONS
1									
2									
3									
4									
5									

During this pregnancy, have you experienced any of the following?

YES	NO	CONDITION	PLEASE EXPLAIN ANY "YES" ANSWERS.
☐	☐	NAUSEA OR VOMITING?	
☐	☐	VAGINAL BLEEDING?	
☐	☐	PAINFUL URINATION?	
☐	☐	ABDOMINAL PAIN?	
☐	☐	FLU, COLD, MEASLES, CHICKENPOX, OR OTHER ILLNESS?	
☐	☐	X-RAYS?	
☐	☐	TAKEN ANY MEDICATION? (ASPIRIN, ANTIBIOTICS, ETC.)	

Name____

During PREVIOUS pregnancies, did you experience any of the following?

YES	NO	CONDITION	PLEASE EXPLAIN ANY "YES" ANSWERS.
☐	☐	A STILLBORN BABY?	
☐	☐	A BIRTH DEFECT OR ABNORMALITY?	
☐	☐	INFANT DEATH FOLLOWING DELIVERY?	
☐	☐	A PREMATURE BABY?	
☐	☐	A BABY WITH A SERIOUS INFECTION?	
☐	☐	A BABY ADMITTED TO THE INTENSIVE CARE UNIT?	
☐	☐	A BABY WITH JAUNDICE	
☐	☐	EXCESSIVE BLEEDING (HEMORRHAGE) AFTER DELIVERY?	
☐	☐	HOSPITALIZATION BEFORE LABOR?	
☐	☐	RHOGAM INJECTIONS	
☐	☐	ANY OTHER UNUSUAL OCCURRENCE?	

Do you have a personal history of any of the following?

YES	NO	CONDITION	PLEASE EXPLAIN ANY "YES" ANSWERS.
GENERAL HEALTH			
☐	☐	OBESITY	
☐	☐	UNDERWEIGHT	
☐	☐	ANY CHRONIC ILLNESS	
☐	☐	MENTAL OR PHYSICAL LIMITATIONS	
☐	☐	POOR DENTAL CONDITION	
HEAD			
☐	☐	CHRONIC HEADACHES	
☐	☐	MIGRAINE HEADACHES	
☐	☐	CONCUSSION OR BLACKOUTS	
☐	☐	EPILEPSY OR SEIZURES	
☐	☐	TUMORS	
EYES			
☐	☐	WEAR GLASSES OR CONTACT LENSES	
☐	☐	BLURRED VISION	
☐	☐	POOR NIGHT VISION	
☐	☐	MOVING SPOTS OR BLIND SPOTS	
EARS			
☐	☐	EAR INFECTIONS	
☐	☐	HEARING LOSS	
☐	☐	WEAR HEARING AIDS	
☐	☐	RUPTURED EAR DRUM	
NOSE			
☐	☐	BROKEN NOSE	
☐	☐	SINUS INFECTIONS	
☐	☐	FREQUENT NOSE BLEEDS	
☐	☐	NASAL SEPTAL DEFECT	
☐	☐	NOSE SURGERY	
THROAT			
☐	☐	TONSILLITIS OR TONSILLECTOMY	
☐	☐	ADENOIDECTOMY	
☐	☐	STREP THROAT	
☐	☐	LARYNGITIS (LOSS OF VOICE)	

Name____

Do you have a personal history of any of the following?

YES	NO	CONDITION	PLEASE EXPLAIN ANY "YES" ANSWERS.
NECK			
☐	☐	LYMPH NODE ABNORMALITIES	
☐	☐	THYROID PROBLEMS OR SURGERY	
☐	☐	INJURY FROM ACCIDENT	
☐	☐	LIMITATION OF MOVEMENT	
RESPIRATORY			
☐	☐	LUNG PROBLEMS	
☐	☐	TUBERCULOSIS (OR INH MEDICATION)	
☐	☐	POSITIVE PPD (TUBERCULOSIS TEST)	
☐	☐	PNEUMONIA OR BRONCHITIS	
☐	☐	ASTHMA	
☐	☐	PNEUMOTHORAX (COLLAPSED LUNG)	
CARDIAC (HEART)			
☐	☐	HEART DISEASE, PROBLEMS, OR IRREGULAR HEART RATE	
☐	☐	HYPERTENSION (HIGH BLOOD PRESSURE)	
☐	☐	HYPOTENSION (LOW BLOOD PRESSURE)	
☐	☐	HEART MURMUR	
GASTROINTESTINAL (STOMACH)			
☐	☐	DIABETES	
☐	☐	ULCERS, STOMACH PROBLEMS	
☐	☐	COLITIS, IRRITABLE BOWEL SYNDROME	
☐	☐	CHRONIC DIARRHEA	
☐	☐	CHRONIC CONSTIPATION	
☐	☐	EATING DISORDER (BULIMIA, ANOREXIA)	
☐	☐	HEMORRHOIDS OR RECTAL PROBLEMS	
☐	☐	GALL BLADDER PROBLEMS	
☐	☐	VEGETARIAN	
URINARY			
☐	☐	BLADDER INFECTIONS (UTI'S)	
☐	☐	KIDNEY INFECTION (PYELONEPHRITIS)	
☐	☐	KIDNEY STONES	
☐	☐	BLADDER OR KIDNEY SURGERY	
☐	☐	LEAKING OF URINE (INCONTINENCE)	
☐	☐	IVP'S (INTRAVENOUS PYELOGRAM)	
HEMATOLOGY			
☐	☐	BLEEDING TENDENCIES	
☐	☐	BLOOD CLOTS OR STROKE	
☐	☐	VARICOSE VEINS	
☐	☐	SICKLE CELL DISEASE OR TRAIT	
☐	☐	ABNORMAL BLOOD TYPE (HEMOGLOBINOPATHY)	
☐	☐	BLOOD TRANSFUSION	
☐	☐	LEUKEMIA	
☐	☐	ANEMIA (LOW BLOOD COUNT OR LOW IRON)	
☐	☐	HEMORRHAGE (EXCESSIVE BLOOD LOSS)	
☐	☐	POSITIVE HIV TEST OR AIDS	
☐	☐	POSITIVE ANTIBODY SCREEN	
☐	☐	HEPATITIS	

Name____

Do you have a personal history of any of the following?

YES	NO	CONDITION	PLEASE EXPLAIN ANY "YES" ANSWERS.
GYNECOLOGY			
☐	☐	PROBLEMS WITH BIRTH CONTROL PILLS	
☐	☐	ABNORMAL PAP SMEAR (DYSPLASIA OR CIN)	
☐	☐	COLPOSCOPY (MICROSCOPIC EVALUATION OF THE CERVIX)	
☐	☐	CRYOSURGERY (FREEZING OF THE CERVIX)	
☐	☐	CONE BIOPSY (REMOVAL OF PART OF THE CERVIX)	
☐	☐	INFERTILITY WORK-UP	
☐	☐	PAINFUL INTERCOURSE	
☐	☐	SEXUAL MOLESTATION, ABUSE, RAPE	
☐	☐	FIBROID TUMORS OF THE UTERUS	
☐	☐	OVARIAN CYSTS	
☐	☐	RECURRENT (FREQUENT) VAGINAL INFECTIONS	
☐	☐	SEXUALLY-TRANSMITTED DISEASE (SYPHILIS, GONORRHEA, CHLAMYDIA, HERPES, TRICHOMONAS)	
☐	☐	PELVIC INFLAMMATORY DISEASE (PID)	
☐	☐	GENITAL WARTS	
☐	☐	MISCARRIAGE	
☐	☐	ABORTIONS (ELECTIVE)	
☐	☐	TUBAL PREGNANCY	
LYMPHATIC SYSTEM			
☐	☐	ABNORMAL LYMPH NODES	
☐	☐	HODGKIN'S DISEASE	
☐	☐	ERYTHEMA NODOSUM	
MUSCULOSKELETAL			
☐	☐	MUSCLE ACHES, PAINS, OR STRAINS	
☐	☐	BROKEN BONES OR INJURY TO MUSCLES OR BONES	
☐	☐	SKELETAL ABNORMALITIES (SCOLIOSIS)	
☐	☐	BIRTH DEFECTS OR GENETIC DEFORMITIES	
☐	☐	PHYSICAL RESTRICTIONS TO MOVEMENT	
☐	☐	EXCESSIVE MUSCLE ACHES OR STRAINS	
☐	☐	CARPAL TUNNEL SYNDROME	
☐	☐	FREQUENTLY SEE A CHIROPRACTER	
NEUROPSYCHIATRIC			
☐	☐	EMOTIONAL PROBLEMS	
☐	☐	PSYCHIATRIC HOSPITALIZATION	
☐	☐	DEPRESSION OR ANXIETY	
☐	☐	CHILDHOOD SEXUAL ABUSE	
☐	☐	MARITAL PROBLEMS	
☐	☐	SEEING A PSYCHIATRIST, PSYCHOLOGIST OR SOCIAL WORKER	
OTHER CONDITIONS			
☐	☐	DO YOU SMOKE TOBACCO?	
☐	☐	DO YOU DRINK ALCOHOLIC BEVERAGES?	
☐	☐	HAVE YOU EVER USED MARIJUANA, SPEED, COCAINE, HEROIN, CRACK, LSD, ACID OR OTHER MIND-ALTERING DRUGS?	
☐	☐	DO YOU EAT UNUSUAL SUBSTANCES (STARCH, PAINT, CLAY)?	
☐	☐	ARE YOU FREQUENTLY EXPOSED TO: LOUD NOISES? CHEMICALS, SOLVENTS, OR PAINT FUMES? HIGH TEMPERATURES? MERCURY, LEAD OR CADMIUM? WHOLE BODY VIBRATIONS (LIKE A JACKHAMMER)? RADIATION? PROLONGED STANDING?	

Name____

ARE YOU ALLERGIC TO ANY MEDICATIONS?	List them.
ARE YOU ALLERGIC TO ANY FOODS?	List them.

Have you had any of the following childhood illnesses?

YES	NO	CONDITION	FOR ANY "YES" ANSWERS, EXPLAIN CIRCUMSTANCES.
☐	☐	CHICKENPOX (VARICELLA) (OR WAS VACCINATED)	
☐	☐	MEASLES (RUBEOLA) (OR WAS VACCINATED)	
☐	☐	RHEUMATIC FEVER	
☐	☐	SCARLET FEVER	
☐	☐	MUMPS (OR WAS VACCINATED)	
☐	☐	GERMAN MEASLES (RUBELLA) (OR WAS VACCINATED)	

Have you had any of the following surgical procedures?

YES	NO	CONDITION	PLEASE EXPLAIN WHEN AND ANY OTHER IMPORTANT FACTS.
☐	☐	GALLBLADDER REMOVAL	
☐	☐	APPENDIX REMOVAL	
☐	☐	BREAST BIOPSY	
☐	☐	BREAST ENLARGEMENT OR REDUCTION SURGERY	
☐	☐	ORAL SURGERY	
☐	☐	PLASTIC SURGERY	
☐	☐	TUBAL SURGERY	
☐	☐	LAPAROSCOPY	
☐	☐	D & C (DILATATION AND CURETTAGE)	
☐	☐	ANY OTHER SURGERY?	

Does any member of your immediate family have any of the following?

YES	NO	CONDITION	PLEASE NOTE WHICH FAMILY MEMBERS ARE AFFECTED.
☐	☐	HEART DISEASE OR HEART ATTACK	
☐	☐	HIGH BLOOD PRESSURE	
☐	☐	KIDNEY OR BLADDER DISEASE	
☐	☐	TUBERCULOSIS	
☐	☐	DIABETES	
☐	☐	EMOTIONAL OR MENTAL DISORDER	
☐	☐	STROKE, BLOOD CLOTS OR PHLEBITIS	
☐	☐	BLOOD VARIATIONS (SICKLE CELL, THALASSEMIA, G6PD)	
☐	☐	BIRTH DEFECTS, DOWN SYNDROME, NEURAL TUBE DEFECTS	
☐	☐	HEMOPHILIA	
☐	☐	MUSCULAR DYSTROPHY OR CYSTIC FIBROSIS	
☐	☐	HUNTINGTON CHOREA	
☐	☐	TAY-SACHS DISEASE	
☐	☐	TWINS OR MULTIPLE BIRTHS	
☐	☐	CANCER	
☐	☐	CHRONIC ILLNESSES	
☐	☐	DRUG ABUSE	
☐	☐	MAJOR OPERATIONS	
☐	☐	PREGNANCY COMPLICATIONS	
☐	☐	DID YOUR MOTHER TAKE ANY HORMONES WHILE CARRYING YOU?	

Name____

PSYCHOSOCIAL NEEDS ASSESSMENT

The purpose of this assessment is to determine if you may need the assistance of our social service staff. Upon review, you may be referred to one of our social workers, who may wish to meet with you to discuss some of your answers or concerns.

I AGREE	I DISAGREE	I'M UNCERTAIN	STATEMENT
☐	☐	☐	I AM HAPPY ABOUT THIS PREGNANCY.
☐	☐	☐	MY LIVING CONDITIONS ARE SATISFACTORY.
☐	☐	☐	I AM FAMILIAR WITH THIS NEIGHBORHOOD AND THE MILITARY BASES IN THE AREA.
☐	☐	☐	MY MARRIAGE IS A HAPPY ONE.
☐	☐	☐	MY HUSBAND HAS NEVER ABUSED ME AND/OR THE CHILDREN.
☐	☐	☐	WHEN MY HUSBAND IS AWAY, I AM OK AND CAN MANAGE MY LIFE WELL.
☐	☐	☐	WHEN MY HUSBAND IS AWAY, I HAVE FRIENDS AND FAMILY TO HELP ME.
☐	☐	☐	WHEN MY HUSBAND IS AWAY AT WORK, I HAVE TRANSPORTATION TO MAKE MY APPOINTMENTS AND GO SHOPPING.
☐	☐	☐	I **DO NOT** FIND LIFE STRESSFUL MOST OF THE TIME.
☐	☐	☐	I AM RARELY DEPRESSED.
☐	☐	☐	MOST OF THE TIME WE HAVE ENOUGH MONEY FOR FOOD AND EXPENSES.
☐	☐	☐	I DON'T DEPEND ON MY HUSBAND FOR EVERYTHING.
☐	☐	☐	MY HUSBAND WILL NOT BE DEPLOYED WHEN MY BABY IS DUE.
☐	☐	☐	I DO NOT TAKE DRUGS OR DRINK ALCOHOLIC BEVERAGES.
☐	☐	☐	MY CHILDHOOD WAS A HAPPY ONE.
☐	☐	☐	I HAVE NEVER BEEN PHYSICALLY OR EMOTIONALLY ABUSED IN MY LIFE.
☐	☐	☐	I SHOULD BE ABLE TO ATTEND MY PRENATAL APPOINTMENTS WITHOUT CHILDCARE CONFLICTS.
☐	☐	☐	I SPEAK AND UNDERSTAND ENGLISH WELL. I PRIMARILY SPEAK: ____________________________________ LANGUAGE
☐	☐	☐	WE DO NOT NEED FINANCIAL ASSISTANCE TO MAINTAIN OUR LIVES.

COMMENTS: PLEASE FEEL FREE TO EXPAND ON ANY OF YOUR ANSWERS TO THE ABOVE QUESTIONS.

Name____

ASSESSMENT OF NUTRITIONAL STATUS

The purpose of this assessment is to determine if you may need the assistance of our dietician staff. Please answer the following questions and make additional comments below.

YES	NO	SOMETIMES	STATEMENT
☐	☐	☐	I AM TAKING MY PRENATAL VITAMIN EVERY DAY.
☐	☐	☐	I SKIP MEALS OR REGULARLY GO LONG PERIODS WITHOUT EATING.
☐	☐	☐	I HAVE A HISTORY OF GESTATIONAL DIABETES.
☐	☐	☐	I HAVE A HISTORY OF ANEMIA.
☐	☐	☐	I HAVE A HISTORY OF EATING DISORDERS, SUCH AS BULIMIA OR ANOREXIA
☐	☐	☐	I HAVE A HISTORY OF HIGH BLOOD PRESSURE.
☐	☐	☐	I AM CURRENTLY HAVING PROBLEMS WITH NAUSEA AND VOMITING.
☐	☐	☐	I AM CURRENTLY HAVING PROBLEMS WITH CONSTIPATION OR DIARRHEA.
☐	☐	☐	I AM CURRENTLY HAVING PROBLEMS WITH LEG CRAMPS.
☐	☐	☐	I AM CURRENTLY HAVING PROBLEMS WITH HEARTBURN.
☐	☐	☐	I AM CURRENTLY HAVING PROBLEMS WITH MILK ALLERGY.
☐	☐	☐	I AM CURRENTLY SMOKING CIGARETTES.
☐	☐	☐	I AM CURRENTLY AGE 18 OR YOUNGER.
☐	☐	☐	I AM CURRENTLY CRAVING NON-FOOD ITEMS SUCH AS CLAY OR DIRT.
☐	☐	☐	I AM CURRENTLY FOLLOWING A SPECIAL DIET.
☐	☐	☐	I AM CURRENTLY UNDERWEIGHT.
☐	☐	☐	I AM CURRENTLY OVERWEIGHT.
☐	☐	☐	I AM HAVING PROBLEMS WITH NOT EATING ENOUGH.
☐	☐	☐	I FEEL I NEED INDIVIDUAL NUTRITIONAL COUNSELING.

PLEASE PLACE A CHECK (✓) BY THE FOODS YOU EAT REGULARLY

☐ NON-FAT OR 1% SKIM MILK	☐ FISH	☐ FRUIT	☐ MARGARINE	☐ WATER
☐ LOW-FAT MILK	☐ CHICKEN/TURKEY	☐ VEGETABLES	☐ ,AUPMMAOSE	☐ JUICE
☐ WHOLE MILK	☐ LEAN RED MEAT	☐ GRAIN CEREAL	☐ SALAD DRESSING	☐ SODA
☐ YOGURT (REG./FROZEN)	☐ EGGS	☐ SUGAR CEREAL	☐ NUTS	☐ KOOLAID
☐ COTTAGE CHEESE	☐ BEANS	☐ WHITE BREAD	☐ COOKING OIL	☐ DESSERTS
☐ CHEESE	☐ HAMBURGER	☐ WHEAT BREAD	☐ CHOCOLATE	☐ CANDY
☐ "CREAMES" (ICE, SOUR, CHEESE, WHIPPED	☐ HOT DOGS	☐ BROWN RICE	☐FAST/FRIED FOODS	☐ COOKIES
	☐ FRIED CHICKEN	☐ WHITE RICE	☐ GRAVY, SAUCES	☐ PASTRIES

ADDITIONAL COMMENTS: