

INITIAL PRENATAL VISIT QUESTIONNAIRE

Name

Age

When was your pregnancy test taken? ___/___/___ Home Other

1st day of your last period? ___/___/___ 1st day of your period before that? ___/___/___

Have you had any spotting or bleeding since becoming pregnant? yes no

If yes, when? _____

Have you been on any method of birth control in the past few months? yes no

If Yes, What method? _____

Have you taken any prescription medication, herbs, or over the counter drugs since becoming pregnant? yes no no If yes, what:

Last Flu Shot? _____ Last Tdap/ Whooping Cough: _____

Habits

Have you ever smoked? yes no Current Smoker Quit (month/ year) _____

If yes, how many packs per day? <1 1 2 3+ For how many years? _____

Do you drink alcohol? yes no If yes, how many drinks per week? <1 1-4 5-10 20+

Substance History Screening

Prenatal substance use has long been identified as a risk factor for the developing fetus, and implicated in pediatric cognitive, neuropsychological and physiologic problems, therefore it is our policy to randomly screen and or test all pregnant patients to ensure the health of you and your baby.

IN YOUR LIFETIME, which of the following substances have you ever used?

Cannabis (marijuana, pot, grass, hash, etc.) yes no

Cocaine (coke, crack, etc.) yes no

Methamphetamine (speed, crystal meth, ice, etc.) yes no

Inhalants (nitrous oxide, glue, gas, paint thinner, etc.) yes no

Sedatives or sleeping pills (Valium, Serepax, Ativan, Xanax, Librium, Rohypnol, GHB, tec.) yes no

Hallucinogens (LSD acid, mushrooms, PCP, Special K, ecstasy, etc.) yes no

Street Opioids (heroin, opium, etc.) yes no

Prescription opioids (fentanyl, oxycodone [OxyContin, Percocet], hydrocodone [Vicodin], methadone, buprenorphine, etc.) yes no

Other- Specify _____

Environmental History

Are you exposed to second hand smoke? yes no

Have you ever had chicken pox? yes no

Have you been exposed or had a rash or viral illness since becoming pregnant? yes no

Have you been exposed to any x-rays since becoming pregnant? yes no

If yes, please list: _____

Are you exposed to hot tubs? (they are dangerous in pregnancy) yes no

Are you exposed to any type of cats? yes no

Have you or your partner travel out of the country recently? yes no

If yes, where did you or your partner travel? _____

Did you or your partner have any signs or symptoms of Zika (including fever, rash, headache, joint pain, red eyes, or muscle pain) when on the trip, or after returning? yes no

Social History

- Within the past year, have you been hit, slapped, kicked or otherwise physically hurt by someone? yes no
- Within the past year, have you or your partner had any sexual partner changes? yes no
- Within the past year, has anyone forced you to have sexual activities? yes no
- Have you or your partner ever had herpes? yes no
- Do you live with someone with TB or exposed to TB? yes no

Prenatal Genetic History

Mother of Baby Ancestry			Father of baby Ancestry		
African American	<input type="checkbox"/> yes	<input type="checkbox"/> no	African American	<input type="checkbox"/> yes	<input type="checkbox"/> no
French Canadian	<input type="checkbox"/> yes	<input type="checkbox"/> no	French Canadian	<input type="checkbox"/> yes	<input type="checkbox"/> no
Jewish	<input type="checkbox"/> yes	<input type="checkbox"/> no	Jewish	<input type="checkbox"/> yes	<input type="checkbox"/> no
Italian, Greek, Middle Eastern	<input type="checkbox"/> yes	<input type="checkbox"/> no	Italian, Greek, Middle Eastern	<input type="checkbox"/> yes	<input type="checkbox"/> no
Asian	<input type="checkbox"/> yes	<input type="checkbox"/> no	Asian	<input type="checkbox"/> yes	<input type="checkbox"/> no
Hispanic	<input type="checkbox"/> yes	<input type="checkbox"/> no	Hispanic	<input type="checkbox"/> yes	<input type="checkbox"/> no
Filipino	<input type="checkbox"/> yes	<input type="checkbox"/> no	Filipino	<input type="checkbox"/> yes	<input type="checkbox"/> no
Other?			Other?		

Please answer all questions:

	Yes	No	Don't know
Will you be 35 years old or older when the baby is due?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Have you, the baby's father or anyone in either family ever had any one of the following disorders:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Thalassemia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Neural Tube Defect, Spina Bifida (open spine), Anencephaly	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Congenital Heart Defect	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Down Syndrome	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Tay-Sachs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Canavan Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sickle Cell Disease or Trait	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Hemophilia or Blood Disorder	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Muscular Dystrophy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cystic Fibrosis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Huntington's Chorea	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Mental Retardation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Any other Genetic or Chromosomal Disorder	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Maternal Metabolic Disorder (eg. Type I Diabetes, PKU)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Do you, the baby's father, or a close family member of either of you have a birth defect or a chromosomal abnormality not listed above?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Have you or the baby's father had a stillborn baby or three or more first trimester miscarriages?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

If you answered yes to any of the above questions, please indicate the condition and the relationship of the affected person to you or the baby's father: _____

Consent for Maternity services from Greater Hartford Women's Health

Congratulations on your pregnancy and thank you for choosing our practice for your care. We believe that patients should enjoy the time of pregnancy, but we are obliged to inform you of some of the health risks associated with pregnancy. We pride ourselves on the open communication we believe our patients want. If, at any time, you have issues you need to discuss, please do so with your physician or midwife. We have also attached a "Congratulations on your pregnancy" Informational letter. Please go over the information provided and bring a list of questions to you initial visit with your provider. Greater Hartford Women's Health operates as a group practice. You will have a primary physician, however, when you go into labor, you may be delivered by the on-call physician, so we encourage you to meet all of the physicians at least once during your pregnancy.

I have read and understand this policy (initials)_____

Blood Transfusions:

In the event of severe obstetrical hemorrhage or low blood count which may be life threatening, **I agree and give my consent to receive blood products.**

I have read and understand this policy (initials)_____

HIV Testing:

HIV TESTING IS REQUIRED BY THE STATE OF CT FOR ALL PREGNANT WOMEN

Below is some information with the following details about HIV testing:

- HIV is the virus that causes AIDS and can be transmitted through unprotected sex (vaginal, anal, or oral sex) with someone who has HIV, contact with blood as in sharing needles (piercing, tattooing, drug equipment including needles), by HIV-infected pregnant women to their infants during pregnancy or delivery, or while breast feeding.
- There are treatments for HIV/AIDS that can help an individual stay healthy.
- Individuals with HIV/AIDS can adopt safe practices to protect uninfected and infected people in their lives from becoming infected or being infected themselves with different strains of HIV.
- Testing is voluntary and can be done anonymously at a public testing center.
- The law protects the confidentiality of HIV test results and other related information
- The law prohibits discrimination based on an individual's HIV status and services are available to help with such consequences.
- The law allows an individual's informed consent for HIV related testing to be valid for such testing until such consent is revoked by the subject of the HIV test or expires by its terms.

If the results show I have HIV, I agree to additional testing which may occur on the sample I provide today to determine the best treatment for me and to help guide HIV prevention programs. I also agree to future tests to guide my treatment. I understand that I can withdraw my consent for future tests at any time. If I test positive for HIV infection, I understand that my health care provider will talk with me about telling partners of possible exposure.

I have read and understand this policy (initials)_____

MR#:

Name of Patient:

Date of Birth:

Place Label Here

DRUG TESTING

Peri-natal alcohol and drug use is an issue critical to the health of mothers and newborns. Substance abuse is associated with adverse pregnancy outcomes, including preterm birth, placental abruption, intrauterine death, low birth weight, and neonatal withdrawal. Exposure to alcohol and certain drugs is a leading preventable cause of birth defects and developmental disabilities in the United States.

I understand that my baby deserves a drug and alcohol free pregnancy. I understand that unannounced random testing may be done throughout my prenatal care to test for drug and alcohol use. The testing is done in order to provide me with the appropriate care and services to assure the best possible outcome for my baby and me.

I have read the above and understand GHWHA policy for drug and alcohol testing. It has been fully explained to me, and I understand and agree to comply with the above. (initials) _____

Signature: _____ Date: _____ Time: _____

Witness: _____