Naperville Women's Healthcare

Obstetrics | Gynecology

Preconception Screening and Counseling

Name _____ Date _____

Birthplace _____ Age _____

Height _____ Weight _____ BMI _____

Occupation _____

Ethnic Background Patient _____ Ethnic Background Husband / Partner _____

Diet and Exercise

What do you consider a healthy weight for yourself? _____ lbs.

Yes No Do you follow a special diet; vegetarian, diabetic, other?

Yes No Do you drink caffeinated beverages?

Yes No Do you eat raw or undercooked food (meat, fish, other)?

Yes No Do you take daily vitamins besides a multivitamin or prenatal vitamin?

Yes No Do you take dietary supplements? _____

Yes No Do you have current or past problems with eating disorders?

Yes No Do you exercise? Type _____ Frequency _____

Notes _____

Home Environment

Yes No Does anyone threaten or physically hurt you?

Yes No Do you have cats?

Notes _____

Lifestyle

Yes No Do you smoke cigarettes or use other tobacco products?

Yes No Are you exposed to second hand smoke?

Yes No Do you drink alcohol?

Yes No Have you ever used recreational drugs; marijuana, cocaine, heroin, ecstasy, meth/ice, or other?

List

Yes No Do you use saunas or hot tubs? Temp

(Maximum temp should be 102 F for a maximum of 15 minutes.)

Medical History

Do you have or have you ever had?

Yes	No	Epilepsy	Yes	No	Diabetes
Yes	No	Asthma	Yes	No	High blood pressure
Yes	No	Heart Disease	Yes	No	Anemia
Yes	No	Kidney or bladder disorders	Yes	No	Thyroid disease
Yes	No	Digestive problems	Yes	No	Hepatitis C
Yes	No	Lupus	Yes	No	Surgeries
Yes	No	Scleroderma			
Yes	No	Depression or other mental health issues			
Yes	No	Other conditions			

List

Medication/Drugs

Yes No Are you taking prescribed drugs?

List

Yes No Are you taking non-prescribed drugs?

List _____

Yes No Do you use any herbal remedies or alternative medicine?

List _____

Genetics

Do you / your family		OR	your partner/partner's family have a history of?		
Yes	No		Yes	No	Hemophilia
Yes	No		Yes	No	Other bleeding disorders
Yes	No		Yes	No	Tay-Sachs disease
Yes	No		Yes	No	Blood diseases; Sickle Cell, Thalassemia
Yes	No		Yes	No	Muscular dystrophy
Yes	No		Yes	No	Down Syndrome/Mental Retardation
Yes	No		Yes	No	Cystic Fibrosis
Yes	No		Yes	No	Birth Defects (spine/heart/kidney, etc)
Yes	No		Yes	No	Spina Bifida or open spine

Yes No Any other genetic disease? _____

Yes No Have you or your partner had three or more spontaneous miscarriages, pregnancy losses, or still births?

Yes No Do you or your partner have any close relatives descended from Jewish people who lived in Eastern Europe, Ashkenazi Jews?

Yes No If yes, have you or your partner been screened for Tay-Sachs disease?

If yes, indicate who was screened and the results. _____

Yes No Do you or your partner have any close relatives descended from Mediterranean countries?

Yes No If yes, have you or your partner been screened for Thalassemia, Cooley's Anemia?

If yes, indicate who was screened and the results. _____

Yes No Are you or your partner African American?

Yes No If yes, have either you or your partner been screened for Sickle cell trait and found to be positive?

If yes, indicate who was screened and the results. _____

Vaccinations

Have you ever been vaccinated for

Yes No Measles, Mumps, and Rubella (German Measles)

Yes No Have you ever been tested to determine if you are immune to Rubella (German Measles)?

If yes, indicate where and when tested and results. _____

Yes No Chickenpox

Yes No If not vaccinated, have you ever had Chickenpox?

Yes No Hepatitis B

Yes No Have you had a Tetanus shot in the last 2 years?

Other

Yes No Do you take folic acid, a multivitamin, or a prenatal vitamin daily?

Yes No Do you see a dentist regularly?

Yes No Do you know your blood type?

If yes, indicate your blood type. _____