

Charles Street Obstetrics~Gynecology Associates, P.A.

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Pre-Natal Questionnaire

Patient Name: _____ Date of Birth: _____

Please answer the following questions as accurately as possible.

	Yes	No
1. Will you be 35 years or older at the time of delivery?	<input type="checkbox"/>	<input type="checkbox"/>
2. Is there a family history of:		
Anencephaly	<input type="checkbox"/>	<input type="checkbox"/>
Cystic Fibrosis	<input type="checkbox"/>	<input type="checkbox"/>
Down's Syndrome	<input type="checkbox"/>	<input type="checkbox"/>
Fragile X Chromosome	<input type="checkbox"/>	<input type="checkbox"/>
Hemophilia	<input type="checkbox"/>	<input type="checkbox"/>
Huntington Chorea	<input type="checkbox"/>	<input type="checkbox"/>
Meningomyelocele	<input type="checkbox"/>	<input type="checkbox"/>
Muscular Dystrophy	<input type="checkbox"/>	<input type="checkbox"/>
Neural Tube Defects	<input type="checkbox"/>	<input type="checkbox"/>
Sickle Cell Disease	<input type="checkbox"/>	<input type="checkbox"/>
Spina Bifida	<input type="checkbox"/>	<input type="checkbox"/>
Tay-Sachs	<input type="checkbox"/>	<input type="checkbox"/>
Thalassemia	<input type="checkbox"/>	<input type="checkbox"/>
3. Is there any history of other genetic chromosomal disorders?	<input type="checkbox"/>	<input type="checkbox"/>
4. Is there a family history of birth defects?	<input type="checkbox"/>	<input type="checkbox"/>
5. Is there a history of a stillborn?	<input type="checkbox"/>	<input type="checkbox"/>
6. Is there a history of recurrent miscarriages?	<input type="checkbox"/>	<input type="checkbox"/>
7. Have you used any of the following since your last menstrual period? (if so, please note what kind, for how long, dosage and frequency)		
Medications _____	<input type="checkbox"/>	<input type="checkbox"/>
Alcohol _____	<input type="checkbox"/>	<input type="checkbox"/>
Tobacco _____	<input type="checkbox"/>	<input type="checkbox"/>
Recreational Drugs _____	<input type="checkbox"/>	<input type="checkbox"/>
8. Do you consume caffeine daily?	<input type="checkbox"/>	<input type="checkbox"/>
9. Are you at risk for:		
HIV	<input type="checkbox"/>	<input type="checkbox"/>
Hepatitis	<input type="checkbox"/>	<input type="checkbox"/>
10. Have you been exposed to TB?	<input type="checkbox"/>	<input type="checkbox"/>
11. Do you or your partner have a history of genital herpes?	<input type="checkbox"/>	<input type="checkbox"/>
12. Have you had a viral illness since your last menstrual period?	<input type="checkbox"/>	<input type="checkbox"/>
13. What is your ethnic background? _____		

Reviewed by: _____ Date: _____