CAPITAL WOMEN'S CARE
CHARLES ST. OB/GYN

Prenatal Questionnaire

Patient Name: _____ DOB: _____

Yes	No	
☐	☐	Will you be 35 years or older at time of delivery?

Do you have any family history of the following?

☐	☐	Thalassemia
☐	☐	Neural tube defect (anencephaly, meningomyelocele, etc.)
☐	☐	Congenital heart defect
☐	☐	Down syndrome
☐	☐	Tay-Sachs (Ashkenazi Jewish, Cajun, French Canadian)
☐	☐	Canavan disease (Ashkenazi Jewish)
☐	☐	Familial Dysautonomia (Ashkenazi Jewish)
☐	☐	Sickle Cell disease or trait (African)
☐	☐	Hemophilia or other blood disorders
☐	☐	Muscular Dystrophy
☐	☐	Cystic Fibrosis
☐	☐	Huntington's Chorea
☐	☐	Intellectual disability or developmental delay
☐	☐	Other inherited genetic or chromosomal disorders
☐	☐	Maternal metabolic disorders (Type 1 DM, PKU)
☐	☐	Patient or baby's father had a child with a birth defect not listed above
☐	☐	Recurrent pregnancy loss or a stillbirth
☐	☐	Blood clot (DVT/PE)
☐	☐	Medications since LMP, including supplements, vitamins, herbs, OTC drugs, illicit or recreational drugs, and alcohol use. (If yes, please list what, how long, dosage, and frequency.)

_____

☐	☐	Have you been exposed to Tuberculosis (TB)?
☐	☐	Do you or your partner have a history of genital herpes?

If yes, who?_____

☐	☐	Have you ever had a MRSA (resistant Staph) infection?

What is your ethnic background? _____

What is your COVID-19 vaccine status?_____