CAPITAL WOMEN'S CARE
Working Together for Women's Health

Prenatal Questionnaire

Patient Name: _____ Date of Birth: _____

Please answer the following questions as accurately as possible:

	Yes	No
Will you be 35 years or older at the time of delivery?	☐	☐
Is there a family history of:		
Cystic fibrosis	☐	☐
Down's syndrome	☐	☐
Fragile X syndrome	☐	☐
Hemophilia	☐	☐
Huntington's chorea	☐	☐
Muscular dystrophy	☐	☐
Neural tube defects (anencephaly, meningomyelocele, etc)	☐	☐
Sickle cell disease	☐	☐
Spina bifida	☐	☐
Spinal muscular atrophy	☐	☐
Tay Sachs disease	☐	☐
Thalassemia	☐	☐
Is there any history of other genetic chromosomal disorders?	☐	☐
Is there a family history of birth defects (especially congenital heart defects)?	☐	☐
Is there a history of stillbirth?	☐	☐
Is there a history of recurrent miscarriages?	☐	☐
Have you used any of the following since your last period?	☐	☐

(If so, please note what kind, for how long, dosage and frequency)

Medications _____

Alcohol _____

Tobacco _____

Recreational drugs _____ _____

Have you been exposed to tuberculosis (TB)?	☐	☐
Do you or your partner have a history of genital herpes?	☐	☐
Have you had a viral illness since your last period?	☐	☐
Have you ever had a MRSA (resistant staph) infection?	☐	☐
Have you or your partner traveled outside this area within the last 6 months?	☐	☐

What is your ethnic background? _____

Reviewed by:_____ Date: _____