Pregnancy Questionnaire - If you are currently pregnant please answer the following questions:

NAME _____ DOB:_____ Age:_____ Date: _____
LAST FIRST

What is your height?_____What is your weight? _____ What did you weigh before you got pregnant? _____
When was your last pap smear? _____ Was it normal? _____
When did you first have a positive pregnancy test? _____
What was the first day of your last period?_____ ❑ sure ❑ approximate ❑ unknown
Was your last period normal amount and duration? ❑ Yes ❑ No

If you answer yes, how much?	Yes / No	before pregnancy	Yes / No	during pregnancy
Do you drink alcohol?	❑ ❑	_____	❑ ❑	_____
Do you smoke? (tobacco or cigars)	❑ ❑	_____	❑ ❑	_____
Do you use marijuana?	❑ ❑	_____	❑ ❑	_____
Do you use street drugs (what type)?	❑ ❑	_____	❑ ❑	_____

Have you, the baby's father, any of your children, or anyone in either of your families ever had any of the following?

You	Baby's father		You	Baby's father	
Yes / No	Yes / No		Yes / No	Yes / No	
❑ ❑	❑ ❑	heart defects at birth	❑ ❑	❑ ❑	Tay-Sachs carrier or disease
❑ ❑	❑ ❑	cleft lip or palate	❑ ❑	❑ ❑	sickle cell trait or disease
❑ ❑	❑ ❑	other birth defects	❑ ❑	❑ ❑	alpha or beta thalassemia
❑ ❑	❑ ❑	mental retardation	❑ ❑	❑ ❑	cystic fibrosis carrier or disease
❑ ❑	❑ ❑	Down syndrome (mongolism)	❑ ❑	❑ ❑	PKU
❑ ❑	❑ ❑	other chromosome abnormalities	❑ ❑	❑ ❑	polycystic kidney disease
❑ ❑	❑ ❑	hydrocephaly ("water brain")	❑ ❑	❑ ❑	a baby die from SIDS (crib death)
❑ ❑	❑ ❑	neural tube defect / spina bifida ("open spine"), meningomyelocele, or anencephaly (no brain)			

Certain diseases are more common in people of certain ethnic and racial groups.
What is your ethnic/racial family background? _____
What is the baby's father's family background? _____
(white/Caucasian, black/African American, Asian, Hispanic, Mediterranean, Italian, Greek, Cajun, Jewish, French-Canadian.)

Yes / No Have you or the father of the baby had any of the following:
❑ ❑ Any history of sexually transmitted diseases (Gonorrhea, Chlamydia, Syphilis, Herpes, genital warts, HIV or AIDS).

Yes / No If you answer yes to any of the following questions please give details in the space below.
❑ ❑ Were you taking birth control when you got pregnant or just before?
❑ ❑ Did you receive any infertility treatments to become pregnant? If yes, what?
❑ ❑ Have you ever had a stillborn child or child that died shortly after birth?
❑ ❑ Have you had three or more miscarriages?
❑ ❑ Since you became pregnant, have you had any vaginal bleeding (more than just spotting)?
❑ ❑ Since you became pregnant, have you been exposed to any radiation, x-rays, or hazardous chemicals?
❑ ❑ Since you became pregnant, have you been sick with a rash or high fever?
❑ ❑ Do you live with anyone with a contagious disease (TB, HIV, Hepatitis, Herpes)?
❑ ❑ Since you became pregnant, have you taken prescription or over-the-counter drugs, mega-vitamins, or herbs?
If yes, please list:

If you have been pregnant before, did you have any of the following complications?

❑ incompetent cervix	❑ pre-eclampsia / PIH	❑ none
❑ preterm labor	❑ placenta previa	❑ gestational diabetes
❑ IUGR (growth restriction)	❑ Rh isoimmunization	❑ placental abruption
❑ problems during labor		❑ shoulder dystocia

For office use: calculate BMI_____ calculate EDD_____ accepted: ❑ Yes ❑ No

PREGNANCY POLICIES AND FREQUENTLY ASKED QUESTIONS

WEBSITE
Our office website: amberhealthcareforwomen.org and amberhealthcareforwomen.com has a pregnancy page filled with information about pregnancy and answers to your most common pregnancy questions.

HOSPITAL AND CALL GROUP
Dr. Serr shares call with Dr. VanKirk, Dr. Pena, Dr. Oliva, Dr. Williams, Dr. Skipitis, and Dr. Keurentjes. Any of these doctors may be present for your delivery. Deliveries at Mercy Hospital in Redding (not at Saint Elizabeth's in Red Bluff or Mercy Mount Shasta). None of these doctors work with midwives or do "home births". The hospital does not allow "VBACs" (vaginal delivery after a prior caesarean section).

OFFICE VISITS and VIDEO POLICY
Your visits to our office will be divided between Dr. Serr and one of our specialized nurse practitioners.
Video-tapping is not allowed during your delivery or during office ultrasounds/visits.

BILLING POLICY
You are responsible for any medical bills that are not paid by your insurance. Our office will collect an "OB deposit" of $300 at your 1st visit, and more in your third trimester (depending upon your insurance benefits). Please refer to our website "Cost of Pregnancy Care" page for details.

DRUG TESTING POLICY
Drug and alcohol use and addiction are very serious conditions that place an unborn child at high risk for birth defects, miscarriage, stillbirth, and other complications of pregnancy. Our office will perform random drug testing on all patient and will dismiss patients who test positive. We do not accept patients who take "medical marijuana" during pregnancy.

VERY HIGH RISK OBSTETRICS POLICY
Our office is not currently accepting very high risk obstetrical patients. This includes patients with Rh isoimmunization, auto-immune diseases, Type I diabetes, poorly controlled high blood pressure, seizure disorders / epilepsy, a high body mass index, and certain other medical conditions. Please ask the office if you are unsure if you would be considered very high risk. Having had a caesarean section does not make a patient very high risk.

GENETIC TESTING IN PREGNANCY
Some genetic diseases are more common to people of certain race, ethnicity of family backgrounds. Please refer to the following sheet for details. We recommend testing (and possible referral to a genetic counsellor or perinatologist) for families with a history of genetic diseases, certain backgrounds, and especially those of Ashkenazi-Jewish descent

I understand and agree to abide by all of the above policies.

Date: _____Name: _____ DOB: _____ Signature: _____

HIV TESTING CONSENT

It is recommended, and required by law, that all pregnant women be offered a blood test for HIV / AIDS. HIV is transmitted by contact with HIV infected blood or bodily fluids (semen, saliva, breast milk), or to a child during pregnancy and delivery. A person can be HIV positive and have no symptoms. You are considered at high risk to have been exposed to HIV / AIDS if you have received a blood transfusion, used IV drugs, had multiple sexual partners, or had sex with a gay or bisexual man, or a man who ever used IV drugs, or a man with HIV / AIDS. **If you are HIV positive, there are medicines you can take that will drastically lower the risk of passing HIV to your unborn child. Our office strongly recommends HIV / AIDS testing, even if you have tested negative in the past.**

□ I wish to have HIV / AIDS testing. (signature and date) _____

OR □ I decline HIV / AIDS testing. (signature and date) _____

GENETIC DISEASE TESTING CONSENTS

- "Genetic diseases" are illnesses that are inherited from parent to child, and hence "run in families".
- You can be a "carrier" for a genetic disease without having symptoms.
- If two "genetic carriers" have a child together, the child may then have the disease.
- If you have already been tested for a genetic disease you never need to be tested again. The results will not change.
- Genetic testing is very expensive and may not be covered by your insurance as a part of "routine pregnancy tests" .
- If both parents test positive for a genetic disease, the fetus can be tested with amniocentesis or CVS.

CYSTIC FIBROSIS TESTING

Cystic fibrosis is a genetic disease which causes severe lung and intestinal disease, and death. A person can be a "carrier" of the cystic fibrosis gene and have no symptoms. The risk of being a carrier is about 1/700. If *both parents* are carriers, the baby has a 25% chance to have cystic fibrosis. The risk of cystic fibrosis is higher in Caucasian (White), French Canadian, and Eastern European Jewish backgrounds.

□ I wish to have cystic fibrosis testing. (signature and date) _____

OR □ I decline cystic fibrosis testing. (signature and date) _____

SICKLE CELL DISEASE

Sickle cell disease is a genetic disease which causes severe anemia, stillbirth, stroke, heart attack, death, and a painful "crisis" in the arms or legs from lack of oxygen. In sickle cell patients, the red blood cells are sickle or crescent shaped, carry less oxygen, and can get stuck in small blood vessels. A carrier has "sickle cell trait" with milder symptoms. If *both parents* are carriers, the baby has a 25% chance to have sickle cell disease. The risk of sickle cell is higher in African, African American, Mediterranean, South and Central American, Caribbean, and Middle Eastern backgrounds.

□ I wish to have sickle cell testing. (signature and date) _____

OR □ I decline sickle cell testing. (signature and date) _____

TAY-SACHS TESTING

Tay-Sachs is a genetic disease (due to a defective gene on chromosome 15) which causes nerve / brain damage to the fetus (during pregnancy). Symptoms appear by a few months of age and the child usually dies by age 5. A person can be a "carrier" of the Tay-Sachs gene and have no symptoms. If *both parents* are carriers, the baby has a 25% chance to have Tay-Sachs. The risk of Tay-Sachs is higher in Eastern European Jewish, Cajun, and French-Canadian backgrounds.

□ I wish to have Tay-Sachs testing. (signature and date)_____

OR □ I decline Tay-Sachs testing. (signature and date) _____

ALPHA-THALASSEMIA and/or βETA-THALASSEMIA

Thalassemia is a genetic disease which causes anemia (mild to severe). Red blood cells use hemoglobin to carry oxygen. Hemoglobin is made of alpha and beta globin chains, which are defective or absent in thalassemia. Thalassemia is more complicated than other genetic diseases because more genes involved. A person can be a "carrier" of thalassemia and have no symptoms, or have thalassemia "minor" (with mild anemia). If *both parents* carry defective genes, the baby can develop thalassemia "major", with stillbirth, severe anemia and death. The risk of thalassemia is higher in Chinese, Pilipino, Taiwanese, and African / African American (also Middle Eastern for alpha thalassemia and Mediterranean, Italian, Greek for beta-thalassemia) backgrounds.

□ I wish to have αlpha & βeta-Thalassemia testing. (signature and date) _____

OR □ I decline αlpha & βeta-Thalassemia testing. (signature and date)_____

SPINAL MUSCULAR ATROPHY (SMA)

SMA is a genetic disease which causes worsening muscle weakness, paralysis and death, due to damage in the motor nerves that control muscle movement. A baby with SMA may not be able to crawl, sit, walk, or (in severe cases) swallow or breathe. The risk of being a carrier is 1/80. If *both parents* are carriers, the baby has a 25% chance to have SMA.

□ I wish to have SMA testing. (signature and date)_____

OR □ I decline SMA testing. (signature and date) _____

REVIEW OF SYSTEMS - Please fill in every box and answer every question.
Please inform the front office if there have been any changes to your address, phone numbers, insurance, employment, or marital status.

What is the reason for your visit today?

1) CONSTITUTIONAL
- ❑ fever ❑ none
- ❑ weight loss
- ❑ weight gain
- ❑ fatigue
- ❑ sleep problems
- ❑ loss of appetite

2) PSYCHIATRIC
- ❑ depression ❑ none
- ❑ severe anxiety
- ❑ crying spells

3) EYES
- ❑ blurred vision ❑ none

4) NEUROLOGIC
- ❑ headache ❑ none
- ❑ seizures
- ❑ fainting or dizziness
- ❑ severe memory loss
- ❑ trouble walking
- ❑ numbness

5) ALLERGIC
- ❑ latex allergy ❑ none
- ❑ betadine allergy
- ❑ sinus drainage
- ❑ sneezing
- ❑ hay fever
- ❑ hives / swelling

6) ENDOCRINE
- ❑ heat intolerance ❑ none
- ❑ cold intolerance
- ❑ excessive hair loss
- ❑ excessive hair growth

7) BREASTS - SKIN
- ❑ breast pain ❑ none
- ❑ breast lumps
- ❑ breast discharge
- ❑ dry or scaly skin
- ❑ rashes / itching
- ❑ skin ulcers or lesions
- ❑ acne

8) MUSCULOSKELETAL
- ❑ joint pain ❑ none
- ❑ muscle weakness

9) EARS - NOSE - THROAT
- ❑ ear pain ❑ none
- ❑ hearing loss
- ❑ ringing in your ears
- ❑ sore throat
- ❑ nose bleeds
- ❑ cold sores

10) HEME - LYMPHATIC
- ❑ bruising easily ❑ none
- ❑ bleeding easily
- ❑ painful varicose veins
- ❑ swollen glands / lymph nodes

11) CARDIOVASCULAR
- ❑ chest pain ❑ none
- ❑ palpitations
- ❑ leg swelling
- ❑ need to sleep propped up
- ❑ short of breath with activity

12) RESPIRATORY
- ❑ wheezing ❑ none
- ❑ cough
- ❑ coughing blood
- ❑ shortness of breath
- ❑ painful breathing

13) GASTROINTESTINAL
- ❑ bloating / gas ❑ none
- ❑ diarrhea
- ❑ constipation
- ❑ abdominal pain
- ❑ bloody stool or black stool
- ❑ indigestion / reflux
- ❑ nausea / vomitting
- ❑ jaundice (yellow skin)

14) GU - URINARY
- ❑ bloody urine ❑ none
- ❑ frequent urination
- ❑ urgent urination
- ❑ painful urination
- ❑ incomplete bladder emptying
- ❑ incontinence of urine

GU - GYNECOLOGY
- ❑ pelvic pain ❑ none
- ❑ low libido (sex drive)
- ❑ vaginal itching
- ❑ vaginal discharge
- ❑ vaginal odor
- ❑ abnormal bleeding

PMS: occuring every month, but only 1-2 weeks before your period
- ❑ angry outbursts ❑ none
- ❑ irritability
- ❑ depression
- ❑ anxiety
- ❑ social withdrawl
- ❑ headache
- ❑ breast pain
- ❑ bloating
- ❑ swelling

Menopause symptoms
- ❑ hot flashes ❑ none
- ❑ night sweats
- ❑ mood swings
- ❑ vaginal dryness

Birth Control Method (current)
- ❑ tubes tied ❑ none
- ❑ vasectomy
- ❑ abstinence
- ❑ rhythm / natural family planning
- ❑ withdrawl ("pulling out")
- ❑ condoms
- ❑ diaphragm
- ❑ IUD
- ❑ DepoProvera
- ❑ Nuvaring
- ❑ birth control patch
- ❑ birth control pills

When was your last period? _____ *If having periods:*
How often do you have a period? _____
How many days do your periods last? _____
Describe your bleeding: ❑ light ❑ moderate ❑ heavy
Describe your mentrual cramps: ❑ mild ❑ moderate ❑ severe

Yes / No
- ❑ / ❑ Do you ever skip periods?
- ❑ / ❑ Do you have bleeding in between your periods?
- ❑ / ❑ Do you soak through to your clothes?
- ❑ / ❑ Do you pass blood clots? How large? _____
- ❑ / ❑ Do your periods limit your activities?

Yes / No
- ❑ / ❑ Are you currently breast feeding?
- ❑ / ❑ Do you do self breast exams? If yes, how often? _____
- ❑ / ❑ Are you sexually active? *If sexually active:*
- ❑ / ❑ Do you have pain with sex?
- ❑ / ❑ Do you have bleeding with sex?
- ❑ / ❑ Do you use condoms?
- ❑ / ❑ Do you currently have more than one sexual partner?

Are your sexual partners: ❑ male ❑ female ❑ both

Yes / No
- ❑ / ❑ Would you like to be tested for sexually transmitted diseases?
- ❑ / ❑ In the past year have you been threatened, slapped, hit, kicked or forced to perform sexual acts without your consent?

SOCIAL HISTORY
What is your current job?
What is your current maritial status?
Yes / No If yes, how much / how often?
- ❑ / ❑ exercise?
- ❑ / ❑ caffeine? (colas / coffee / tea)
- ❑ / ❑ alcohol?
- ❑ / ❑ smoking?
- ❑ / ❑ street drugs?

Yes / No For Returning Patients: (If yes, please detail)
- ❑ / ❑ Have you developed any new medical conditions?
- ❑ / ❑ Have you had any surgeries, serious illness, or injuries?

ALLERGIES: ❑ Yes / ❑ No Are you allergic to any medicines, any foods, latex, adhesive tape, or x-ray dye? If yes please detail.

MEDICATIONS
Yes / No If yes, how much / how often?
- ❑ / ❑ Do you take any prescription and over-the-counter medicines?
- ❑ / ❑ Do you take other herbs or supplements?
- ❑ / ❑ Do you take calcium or other vitamins?

Date: _____ Name: _____ DOB: _____

Please fill in every box and answer every question. If you answer yes, please give details and year of diagnosis

PERSONAL MEDICAL AND SURGICAL HISTORY

Yes / No Have YOU ever had the following?

- ❑ ❑ hyperthyroid (high)
- ❑ ❑ hypothyroid (low)
- ❑ ❑ diabetes
- ❑ ❑ glaucoma
- ❑ ❑ bladder interstitial cystitis
- ❑ ❑ frequent bladder infections
- ❑ ❑ kidney infections
- ❑ ❑ kidney stones
- ❑ ❑ kidney failure
- ❑ ❑ migraine headaches
- ❑ ❑ anemia
- ❑ ❑ varicose veins or superficial thrombophlebitis
- ❑ ❑ deep venous thrombosus (DVT) - blood clots in legs
- ❑ ❑ pulmonary embolus (PE) - blood clots in lungs
- ❑ ❑ systemic lupus erythematosus (SLE)
- ❑ ❑ anti-phospholipid antibody syndrome
- ❑ ❑ seizures / epilepsy
- ❑ ❑ osteopenia or osteoporosis
- ❑ ❑ arthritis
- ❑ ❑ asthma
- ❑ ❑ COPD
- ❑ ❑ heart murmur
- ❑ ❑ mitral valve prolapse or other valvular disease
- ❑ ❑ coronary artery disease or heart attack
- ❑ ❑ high cholesterol
- ❑ ❑ high blood pressure
- ❑ ❑ stroke
- ❑ ❑ gastric reflux / GERD
- ❑ ❑ hiatal hernia
- ❑ ❑ ulcers (stomach or intestines)
- ❑ ❑ liver cirrhosis
- ❑ ❑ gallstones
- ❑ ❑ irritable bowel disease
- ❑ ❑ Crohn's disease or ulcerative colitis
- ❑ ❑ diverticulosis or diverticulitis
- ❑ ❑ eating disorder: anorexia or bulimia
- ❑ ❑ clinical depression, or anxiety, or bipolar disorder
- ❑ ❑ alcoholism or drug abuse
- ❑ ❑ skin disease: psoriasis, eczema, or lichen sclerosus
- ❑ ❑ breast cancer
- ❑ ❑ ovarian cancer
- ❑ ❑ colon cancer
- ❑ ❑ skin cancer
- ❑ ❑ other cancer
- ❑ ❑ other chronic or serious illness:
- ❑ ❑ fibrocystic breast disease
- ❑ ❑ uterine fibroids
- ❑ ❑ polycystic ovarian syndrome (PCOS)
- ❑ ❑ endometriosis
- ❑ ❑ infertility
- ❑ ❑ abnormal pap smear (how treated?)
- ❑ ❑ Have you ever been physically abused?
- ❑ ❑ Have you ever been sexually abused or raped?
- ❑ ❑ Have you ever had a blood transfusion?
- ❑ ❑ Are you a Jehovas Witness who refuses blood products?
- ❑ ❑ Have you had any surgeries?

INFECTIOUS DISEASE HISTORY Have YOU ever had:

Yes / No

- ❑ ❑ chicken pox
- ❑ ❑ shingles
- ❑ ❑ positive PPD test
- ❑ ❑ tuberculosis (TB)
- ❑ ❑ measles, mumps, rubella, polio, malaria, or yellow fever
- ❑ ❑ Have you been vaccinated for ❑ HPV / ❑ HepB / ❑ TB?
- ❑ ❑ sexually transmitted diseases:
  - ❑ Gonorrhea ❑ Chlamydia ❑ PID
  - ❑ HIV / AIDS ❑ Trichomonas ❑ syphilis
  - ❑ Herpes ❑ genital warts ❑ HPV on pap smear

Yes / No

- ❑ ❑ scarlet fever
- ❑ ❑ hepatitis A
- ❑ ❑ hepatitis B
- ❑ ❑ MRSA skin infection

FAMILY HISTORY If yes, which relative and age when diagnosed?

Yes / No

- ❑ ❑ DVT or PE (blood clots in the legs or lungs)
- ❑ ❑ stroke or heart attack before age 60
- ❑ ❑ diabetes
- ❑ ❑ high cholesterol
- ❑ ❑ high blood pressure
- ❑ ❑ osteoporosis
- ❑ ❑ breast cancer
- ❑ ❑ ovarian cancer
- ❑ ❑ colon cancer
- ❑ ❑ other cancer

GENETIC HISTORY Do you or your family have any of the following?

Yes / No

- ❑ ❑ Factor 5 Leiden mutation or other "clotting" diseases
- ❑ ❑ Factor 8 vonWillebrand deficiency or "bleeding" diseases
- ❑ ❑ Alpha or Beta thalassemia or sickle cell trait or disease
- ❑ ❑ Huntington chorea
- ❑ ❑ muscular dystrophy

PREGNANCY HISTORY

____ total number of pregnancies
____ full term births (after 37 wks)
____ preterm birth (before 37 wks)
____ tubal / ectopic pregnancies
____ miscarriages
____ stillbirth
____ abortions
____ living children

Date of birth	Term or preterm?	vaginal or cesarean?	Baby's sex	Baby's weight	Complications?

Date: _____ Name: _____ DOB: _____