Dr. Glena Davis

Obstetrician & Gynecologist

108 SW 6th Ave, Mineral Wells, Tx 76067 ● www.davisob.com ● Phone:940-328-1200 ● Fax:940-328-1205

Patient Name:_____ Date of Birth:_____

Prenatal Questionnaire

Gynecological History		Infection History	
Have you ever had?		**Have you ever had?**	
☐ **Y** ☐ **N**	Breast Disease	☐ **Y** ☐ **N**	Chickenpox
☐ **Y** ☐ **N**	An Abnormal Pap Smear	☐ **Y** ☐ **N**	Chickenpox Vaccine
☐ **Y** ☐ **N**	Infertility/Artificial Insemination Treatment	☐ **Y** ☐ **N**	Genital Herpes
☐ **Y** ☐ **N**	DES Exposure	☐ **Y** ☐ **N**	A Partner With A History of Genital Herpes
☐ **Y** ☐ **N**	Gyn Disorder	☐ **Y** ☐ **N**	A STD (GC, Chlamydia, Syphilis, HIV)
Medical History		**Risk Factors**	
Have you ever had?		**Have you ever had?**	
☐ **Y** ☐ **N**	Disease in your Head, Eyes, Ears, Nose, or Throat	☐ **Y** ☐ **N**	Do you Smoke
☐ **Y** ☐ **N**	Heart Disease	☐ **Y** ☐ **N**	Have you ever smoked in the past
☐ **Y** ☐ **N**	Hypertension	☐ **Y** ☐ **N**	If yes, what year did you quit: _____
☐ **Y** ☐ **N**	Pre-Ecclampsia	☐ **Y** ☐ **N**	Do you currently consume Alcoholic beverages
☐ **Y** ☐ **N**	Lung Problems	☐ **Y** ☐ **N**	If yes, how often _____ and how many drinks _____
☐ **Y** ☐ **N**	GI/Liver/Hepatitis Disease	☐ **Y** ☐ **N**	Prior to this pregnancy did you consume Alcoholic beverages
☐ **Y** ☐ **N**	Gynecologic or Urinary Disorder	☐ **Y** ☐ **N**	If yes, how often _____ and how many drinks _____
☐ **Y** ☐ **N**	Frequent Urinary Tract Infections	☐ **Y** ☐ **N**	Do you currently use illegal drugs
☐ **Y** ☐ **N**	Diabetes	☐ **Y** ☐ **N**	If yes, what_____
☐ **Y** ☐ **N**	Gestational Diabetes	☐ **Y** ☐ **N**	Do you have a history of alcohol or substance abuse
☐ **Y** ☐ **N**	Thyroid disease	☐ **Y** ☐ **N**	Have you ever sought and/or received treatment for alcohol or drug problems? When_____
☐ **Y** ☐ **N**	Neurological Disorders		
☐ **Y** ☐ **N**	Seizures	☐ **Y** ☐ **N**	Have you used any medications since your last menstrual period? What_____
☐ **Y** ☐ **N**	Migraine		
☐ **Y** ☐ **N**	Bleeding/Clotting Disorder	☐ **Y** ☐ **N**	Did you use Folic Acid prior to your pregnancy
☐ **Y** ☐ **N**	Depression		
☐ **Y** ☐ **N**	Postpartum Depression	☐ **Y** ☐ **N**	Have you been exposed to X-rays since your last menstrual period
☐ **Y** ☐ **N**	Anxiety Disorder		
☐ **Y** ☐ **N**	Musculoskeletal Disorders	**Infection Risk History**	
☐ **Y** ☐ **N**	Skin Disorders	☐ **Y** ☐ **N**	Are you at High Risk for Hepatitis B Infection
☐ **Y** ☐ **N**	Transfusions		

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☐ Y ☐ N	Prior C-Sections	☐ Y ☐ N	Are you immunized against Hepatitis B
☐ Y ☐ N	Other Surgery:_____		
☐ Y ☐ N	Sexual Abuse	☐ Y ☐ N	Have you ever been exposed to Tuberculosis (TB)
☐ Y ☐ N	Domestic Violence	**Environmental Exposures**	
Has anyone in your family ever had?		☐ Y ☐ N	Have you had a rash, viral or febrile illness since your last menstrual period
☐ Y ☐ N	Diabetes		
☐ Y ☐ N	Hypertension	☐ Y ☐ N	Do you have any occupational exposure to children? If yes, what is your occupation_____
☐ Y ☐ N	Multiple Gestation		
☐ Y ☐ N	Other:_____	☐ Y ☐ N	Do you have a history of Parvovirus (Fifth Disease)
		☐ Y ☐ N	Have you been exposed to any chemicals
		☐ Y ☐ N	Have you been exposed to cat litter since your last menstrual period
		☐ Y ☐ N	Have you ever had other exposure you think we should be aware of? If yes, What_____

Patient's Family Genetic History		**Father of Baby's Genetic History**	
Do you have a family history of:		**Does the father have a family history of:**	
☐ Y ☐ N	Thalassemia	☐ Y ☐ N	Thalassemia
☐ Y ☐ N	Neural Tube Defect	☐ Y ☐ N	Neural Tube Defect
☐ Y ☐ N	Down Syndrome	☐ Y ☐ N	Down Syndrome
☐ Y ☐ N	Tay-Sachs	☐ Y ☐ N	Tay-Sachs
☐ Y ☐ N	Sickle Cell Disease/Trait	☐ Y ☐ N	Sickle Cell Disease/Trait
☐ Y ☐ N	Hemophilia	☐ Y ☐ N	Hemophilia
☐ Y ☐ N	Muscular Dystrophy	☐ Y ☐ N	Muscular Dystrophy
☐ Y ☐ N	Cystic Fibrosis	☐ Y ☐ N	Cystic Fibrosis
☐ Y ☐ N	Huntington's Disease	☐ Y ☐ N	Huntington's Disease
☐ Y ☐ N	Mental Retardation	☐ Y ☐ N	Mental Retardation
☐ Y ☐ N	Fragile X	☐ Y ☐ N	Fragile X
☐ Y ☐ N	Other Genetic/Chromosomal defects	☐ Y ☐ N	Other Genetic/Chromosomal defects
☐ Y ☐ N	Stillbirth	☐ Y ☐ N	Stillbirth
☐ Y ☐ N	Other (spina bifida, heart defect, blood disorder)	☐ Y ☐ N	Other (spina bifida, heart defect, blood disorder)

Other Questions	
☐ Y ☐ N	Will you be 35 years or older when the baby is due? Age when due_____

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☐ **Y** ☐ **N**	Are you or the baby's father related to each other (ie. cousins)? Relation_____
☐ **Y** ☐ **N**	Have you had three or more pregnancies that ended in miscarriage?
☐ **Y** ☐ **N**	Have you delivered a premature baby?
☐ **Y** ☐ **N**	Have you or the baby's father had a stillborn baby, a baby who died around the time of delivery, or a baby who was small for gestational age?
☐ **Y** ☐ **N**	Where you ancestors came from may sometimes give us important information about the health of your baby. Are you or the baby's father from any of these ethnic/racial groups: Jewish, Black, Asian, Mediterranean (Greek , Italian)?
☐ **Y** ☐ **N**	Have you or the baby's father ever been screened to see if either of you are carriers of the gene for any of the following: Tay-Sachs, Sickle Cell, Thalaseemia, or Cystic Fibrosis?
☐ **Y** ☐ **N**	Do you think you are at an increased risk of having a baby with a birth defect or genetic disorder? If yes, which defect or disorder_____ Why do you think you are at an increased risk _____
☐ **Y** ☐ **N**	At any time during the first two months of your pregnancy, have you had a rash or a fever of 103°F or greater?
☐ **Y** ☐ **N** ☐ **Unsure**	Have you ever had a serious pelvic infection or pelvic inflammatory disease (PID)?
☐ **Y** ☐ **N** ☐ **Unsure**	Do you think any of your male sexual partners ever had sex with other men?
☐ **Y** ☐ **N** ☐ **Unsure**	Have you or your sexual partners ever used IV street drugs?
☐ **Y** ☐ **N** ☐ **Unsure**	Have you had sex with two or more partners in the last 12 months?
☐ **Y** ☐ **N** ☐ **Unsure**	Do you think any of your sexual partners may have HIV or AIDS?
☐ **Y** ☐ **N** ☐ **Unsure**	Have you or your sexual partners ever had a blood transfusion?
☐ **Y** ☐ **N**	Do you feel safe in your personal relationship?
☐ **Y** ☐ **N**	Do you feel safe within your home?
☐ **Y** ☐ **N**	Do you feel safe in your own neighborhood?
☐ **Y** ☐ **N**	Have you ever had your feelings repeatedly hurt, been repeatedly put down, or experienced any other kinds of emotional grief?
If you're under the age of 18, and you answer yes to the following questions, your care provider must report this information to Child Protective Services.	
☐ **Y** ☐ **N**	Are being or have you ever been hit, slapped, kicked, pushed, or otherwise physically hurt? If yes, by whom? ☐ Husband ☐ Family Member ☐ Ex-Husband ☐Stranger ☐Partner ☐Other(specify)_____
☐ **Y** ☐ **N**	Are you experiencing or have ever experienced uncomfortable touching or forced sexual contact? If yes, by whom? ☐ Husband ☐ Family Member ☐ Ex-Husband ☐Stranger ☐Partner ☐Other(specify)_____

It is Dr. Davis' goal to provide the best possible treatment to all of her patients. It is important that you fully disclose all requested information to ensure you have not only the proper treatment to the best possible treatment.
By signing below you affirm that you have disclosed all requested medical information to the best of your recollection and that you hold harmless Dr. Glena Davis and her employees harmless for any errors or omissions to the requested information.

Patient's Signature:_____ Today's Date:_____

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