



## PRECONCEPTIONAL HEALTH ASSESSMENT

Date of Appointment: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

Patient Name (print): \_\_\_\_\_ Chart#: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_ Height: \_\_\_\_\_ Weight: \_\_\_\_\_

Race \_\_\_\_\_ Religion \_\_\_\_\_

Your Occupation \_\_\_\_\_ Your Employer \_\_\_\_\_

Father of Baby \_\_\_\_\_ Age \_\_\_\_\_

Occupation \_\_\_\_\_ Employer \_\_\_\_\_

What is your main interest in seeking preconceptional counseling? \_\_\_\_\_

***In order that we can address your specific interests and concerns, we ask that you complete the following questionnaire. Please check (✓) Yes or No.***

### SOCIAL HISTORY

| Do you: |    |   |
|---------|----|---|
| Yes     | No |   |
|         |    | Drink beer, wine or hard liquor?  |
|         |    | Smoke cigarettes or use any other tobacco products?   |
|         |    | Use marijuana, cocaine or any other recreational drugs?   |
|         |    | Use lead or chemicals at home or at work? If yes, list the specific chemicals if you know them: |
|         |    | Work with radiation?  |
|         |    | Participate in an exercise program?   |

### NUTRITIONAL HISTORY

| Do you: |    |   |
|---------|----|---|
| Yes     | No |   |
|         |    | Practice vegetarianism?                                 |
|         |    | Eat unusual substances, such as laundry starch or clay? |
|         |    | Have a history of bulimia or anorexia?                  |
|         |    | Eat a special diet? If yes, describe?                   |
|         |    | Have an intolerance for milk?                           |

### MEDICAL HISTORY

|  |    |  |
|--|----|--|
| Do you now have, or have you ever had: |    |  |
| Yes                                    | No |  |
|  |    | Diabetes?  |
|  |    | Thyroid disease?   |
|  |    | Phenylketonuria (PKU)?   |
|  |    | Asthma?  |
|  |    | Heart disease?   |
|  |    | High blood pressure?   |
|  |    | Deep venous thrombosis (blood clot)?   |
|  |    | Kidney disease?  |
|  |    | Systemic lupus erythematosus (SLE)   |
|  |    | Epilepsy?  |
|  |    | Sickle cell disease?   |
|  |    | Cancer?  |
|  |    | Other health problems that require medical or surgical care? If yes, describe: |

### INFECTIOUS DISEASE HISTORY

|  |    |  |
|--|----|--|
| Do you or your partner, have a history of: |    |  |
| Yes  | No |  |
|  |    | Recurrent genital infections?  |
|  |    | Herpes simplex?  |
|  |    | Chlamydia infection?   |
|  |    | Human papillomavirus (genital warts)?  |
|  |    | Gonorrhea?   |
|  |    | Syphilis?  |
|  |    | Viral hepatitis or high-risk behaviors, including use of intravenous street drugs, intimate bisexual/homosexual contact, or multiple partners?                           |
|  |    | Acquired immunodeficiency syndrome (AIDS) or high-risk behaviors, including use of intravenous street drugs, intimate bisexual/homosexual contact, or multiple partners? |
|  |    | Occupational exposure to the blood or bodily secretions of others?   |
|  |    | Blood transfusions?  |

|         |    |                                      |
|---------|----|--------------------------------------|
| Do you: |    |                                      |
| Yes     | No |                                      |
|         |    | Own or work with cats?               |
|         |    | Have documented immunity to rubella? |
|         |    | Have a history of chicken pox?       |

### MEDICATION HISTORY

|         |    |   |
|---------|----|---|
| Do you: |    |   |
| Yes     | No |   |
|         |    | Routinely or occasionally take prescribed medications? If yes, list names and dosages:                                      |
|         |    | Routinely or occasionally take over-the-counter medications, including herbal supplements and vitamins? If yes, list names: |

## REPRODUCTIVE HISTORY

Number of times you have been pregnant: \_\_\_\_\_ Number of living children: \_\_\_\_\_

|                           |    |   |
|---------------------------|----|---|
| Do you have a history of: |    |   |
| Yes                       | No |   |
|                           |    | Uterine or cervical abnormalities?                                  |
|                           |    | Two or more pregnancies that ended in first-trimester miscarriages? |
|                           |    | Pregnancy that ended between 14 and 28 weeks of gestation?          |
|                           |    | Fetal death?  |
|                           |    | Infant who weighed less than 5 ½ pounds at birth?                   |
|                           |    | Infant who was admitted to a neonatal intensive care unit?          |
|                           |    | Infant with a birth defect?   |

## FAMILY HISTORY

|  |    |  |
|--|----|--|
| Do you, or your partner, or members of either of your families, including offspring, have: |    |  |
| Yes  | No |  |
|  |    | Hemophilia?  |
|  |    | Thalassemia?   |
|  |    | Tay-Sachs disease?   |
|  |    | Sickle-cell disease or trait?  |
|  |    | Phenylketonuria (PKU)?   |
|  |    | Cystic fibrosis?   |
|  |    | Birth defects?   |
|  |    | Mental retardation?  |
|  |    | Are you and the partner related outside of marriage (such as cousins)?   |
|  |    | Are you or the baby's father of Eastern European (Ashkenazi) Jewish ancestry?                                      |
|  |    | Are you or the baby's father African American?   |
|  |    | Have either of you been screened for sickle-cell disease?  |
|  |    | If yes, indicate who and the results:  |
|  |    | Are you or the baby's father of Italian, Greek, Mediterranean, Philippine, or Southeast Asian ancestry background? |

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