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 intravenour 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:

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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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