The Women's Center of Southern New England
A member of Women's Health Connecticut

MR#: ☐☐☐☐☐☐☐
Name of Patient:
Date of Birth:
Place Label Here

INITIAL PRENATAL VISIT QUESTIONNAIRE

Name _____ ***Age*** _____

When was your pregnancy test taken? ___/____/___ ☐ Home ☐ Other

1st day of your last period? ___/___/___ 1st day of your period before that? ___/___/___

Have you had any spotting or bleeding since becoming pregnant? ☐ yes ☐ no

If yes, when? _____

Have you been on any method of birth control in the past few months? ☐ yes ☐ no

If Yes, What method?_____

Have you taken any prescription medication, herbs, or over the counter drugs since becoming pregnant? ☐ yes ☐ no no If yes, what:

_____

_____

Last Flu Shot? _____ Last Tdap/ Whooping Cough: _____

Habits

Have you ever smoked? ☐ yes ☐ no ☐ Current Smoker ☐ Quit (month/ year)_____

If yes, how many packs per day? ☐<1 ☐ 1 ☐ 2 ☐ 3+ For how many years? _____

Do you drink alcohol? ☐ yes ☐ no If yes, how many drinks per week? ☐<1 ☐ 1-4 ☐ 5-10 ☐ 20+

Substance History Screening

Prenatal substance use has long been identified as a risk factor for the developing fetus, and implicated in pediatric cognitive, neuropsychological and physiologic problems, therefore it is our policy to randomly screen and or test all pregnant patients to ensure the health of you and your baby.

IN YOUR LIFETIME, which of the following substances have you ever used?

Cannabis (marijuana, pot, grass, hash, etc)	☐ yes ☐ no
Cocaine (coke, crack, etc.)	☐ yes ☐ no
Methamphetamine (speed, crystal meth, ice, etc.)	☐ yes ☐ no
Inhalants)nitrous oxide, glue, gas, paint thinner, etc.)	☐ yes ☐ no
Sedatives or sleeping pills (Valium, Serepax, Ativan, Xanax, Librium, Rohypnol, GHB, tec.)	☐ yes ☐ no
Hallucinogens (LSD acid, mushrooms, PCP, Special K, ecstasy, etc.)	☐ yes ☐ no
Street Opioids (heroin, opium, etc.)	☐ yes ☐ no
Prescription opioids (fentanyl, oxycodone [OxyContin, Percocet], hydrocodone [Vicodin], methadone, buprenorphine, etc.)	☐ yes ☐ no

Other- Specify _____

Environmental History

Are you exposed to second hand smoke?	☐ yes ☐ no
Have you ever had chicken pox?	☐ yes ☐ no
Have you been exposed or had a rash or viral illness since becoming pregnant?	☐ yes ☐ no
Have you been exposed to any x-rays since becoming pregnant?	☐ yes ☐ no
If yes, please list: _____	
Are you exposed to hot tubs? (they are dangerous in pregnancy)	☐ yes ☐ no
Are you exposed to any type of cats?	☐ yes ☐ no
Have you or your partner travel out of the country recently?	☐ yes ☐ no
If yes, where did you or your partner travel?_____	
Did you or your partner have any signs or symptoms of Zika (including fever, rash, headache, joint pain, red eyes, or muscle pain) when on the trip, or after returning?	☐ yes ☐ no

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Social History

Within the past year, have you been hit, slapped, kicked or otherwise physically hurt by someone?	☐ yes ☐ no
Within the past year, have you or your partner had any sexual partner changes?	☐ yes ☐ no
Within the past year, has anyone forced you to have sexual activities?	☐ yes ☐ no
Have you or your partner ever had herpes?	☐ yes ☐ no
Do you live with someone with TB or exposed to TB?	☐ yes ☐ no

Prenatal Genetic History

Mother of Baby Ancestry			Father of baby Ancestry		
African American	☐ yes	☐ no	African American	☐ yes	☐ no
French Canadian	☐ yes	☐ no	French Canadian	☐ yes	☐ no
Jewish	☐ yes	☐ no	Jewish	☐ yes	☐ no
Italian, Greek, Middle Eastern	☐ yes	☐ no	Italian, Greek, Middle Eastern	☐ yes	☐ no
Asian	☐ yes	☐ no	Asian	☐ yes	☐ no
Hispanic	☐ yes	☐ no	Hispanic	☐ yes	☐ no
Filipino	☐ yes	☐ no	Filipino	☐ yes	☐ no
Other?			Other?		

Please answer all questions:	Yes	No	Don't know
Will you be 35 years old or older when the baby is due?	☐	☐	☐
Have you, the baby's father or anyone in either family ever had any one of the following disorders:	☐	☐	☐
Thalassemia	☐	☐	☐
Neural Tube Defect, Spina Bifida (open spine), Anencephaly	☐	☐	☐
Congenital Heart Defect	☐	☐	☐
Down Syndrome	☐	☐	☐
Tay-Sachs	☐	☐	☐
Canavan Disease	☐	☐	☐
Sickle Cell Disease or Trait	☐	☐	☐
Hemophilia or Blood Disorder	☐	☐	☐
Muscular Dystrophy	☐	☐	☐
Cystic Fibrosis	☐	☐	☐
Huntington's Chorea	☐	☐	☐
Mental Retardation	☐	☐	☐
Any other Genetic or Chromosomal Disorder	☐	☐	☐
Maternal Metabolic Disorder (eg. Type I Diabetes, PKU)	☐	☐	☐
Do you, the baby's father, or a close family member of either of you have a birth defect or a chromosomal abnormality not listed above?	☐	☐	☐
Have you or the baby's father had a stillborn baby or three or more first trimester miscarriages?	☐	☐	☐

If you answered yes to any of the above questions, please indicate the condition and the relationship of the affected person to you or the baby's father:_____

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Consent for Maternity services from Women's Center of Southern New England

Congratulations on your pregnancy and thank you for choosing our practice for your care. We believe that patients should enjoy the time of pregnancy, but we are obliged to inform you of some of the health risks associated with pregnancy. We pride ourselves on the open communication we believe our patients want. If, at any time, you have issues you need to discuss, please do so with your physician or midwife. We have also attached a "Congratulations on your pregnancy" Informational letter. Please go over the information provided and bring a list of questions to you initial visit with your provider. The women Center of SNE operate as a group practice. You will have a primary physician, however, when you go into labor, you may be delivered by the on-call physician, so we encourage you to meet all of the physicians at least once during your pregnancy.

I have read and understand this policy (initials)_____

Blood Transfusions:

In the event of severe obstetrical hemorrhage or low blood count which may be life threatening, **I agree and give my consent to receive blood products.**

I have read and understand this policy (initials)_____

HIV Testing:

HIV TESTING IS REQUIRED BY THE STATE OF CT FOR ALL PREGNANT WOMEN

Below is some information with the following details about HIV testing:

- HIV is the virus that causes AIDS and can be transmitted through unprotected sex (vaginal, anal, or oral sex) with someone who has HIV, contact with blood as in sharing needles (piercing, tattooing, drug equipment including needles), by HIV-infected pregnant women to their infants during pregnancy or delivery, or while breast feeding.
- There are treatments for HIV/AIDS that can help an individual stay healthy.
- Individuals with HIV/AIDS can adopt safe practices to protect uninfected and infected people in their lives from becoming infected or being infected themselves with different strains of HIV.
- Testing is voluntary and can be done anonymously at a public testing center.
- The law protects the confidentiality of HIV test results and other related information
- The law prohibits discrimination based on an individual's HIV status and services are available to help with such consequences.
- The law allows an individual's informed consent for HIV related testing to be valid for such testing until such consent is revoked by the subject of the HIV test or expires by its terms.

If the results show I have HIV, I agree to additional testing which may occur on the sample I provide today to determine the best treatment for me and to help guide HIV prevention programs. I also agree to future tests to guide my treatment. I understand that I can withdraw my consent for future tests at any time. If I test positive for HIV infection, I understand that my health care provider will talk with me about telling partners of possible exposure.

I have read and understand this policy (initials)_____

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DRUG TESTING CONSENT

Peri-natal alcohol and drug use is an issue critical to the health of mothers and newborns. Substance abuse is associated with adverse pregnancy outcomes, including preterm birth, placental abruption, intrauterine death, low birth weight, and neonatal withdrawal. Exposure to alcohol and certain drugs is a leading preventable cause of birth defects and developmental disabilities in the United States.

I understand that my baby deserves a drug and alcohol free pregnancy. I understand that unannounced random testing may be done throughout my prenatal care to test for drug and alcohol use. The testing is done in order to provide me with the appropriate care and services to assure the best possible outcome for my baby and me.

I have read the above and understand WCSN policy for drug and alcohol testing. It has been fully explained to me, and I understand and agree to comply with the above. (initials)_____

Signature: _____Date: _____ Time: _____
Witness:_____