BERT BLACKBURN M.D.
PRENATAL QUESTIONNAIRE

NAME: _____ **DATE:**_____
YOUR AGE: _____ **HUSBAND/PARTNER AGE:**_____

Please read these questionas carefully and answer ALL questions. If you don't understand a question the medical assistant or doctor will help you. If you prefer the questions in spanish please inform us.

FAMILY ILLNESS

These questions may apply to you, your husband, the baby's father, your or his blood relatives. Examples are in parenthesis ().

1. Have you, your husband, children or blood relatives had any of the following:

A High blood pressure YES ____ NO ____
If yes, whom? _____

B Malignancy (cancer) YES ____ NO ____
If yes, whom? _____

C Heart disease (Rheumatic fever, angina, etc.) YES ____ NO ____

D Blood diseases (HIV, Heapatis, Haemophilia, Sickle Cell Anemia, clotting problems, Thalassemia, Leukemia etc..) YES ____ NO ____

E Congenital defects (heart defects, club foot, hairlip or palate, hearing) YES ____ NO ____

F Kidney or uniary defects YES ____ NO ____

G Muscular diseases (Muscular Dystrophy, etc..) YES ____ NO ____

H Down's Syndrome (Mongoloid) YES ____ NO ____

I Spinal defects (Spina Bifida or "open spine") YES ____ NO ____

J Cystic Fibrosis ("mucous lung") YES ____ NO ____

K Mental retardation (Down's Sndrome or Mongolism) YES ____ NO ____

L Psychiatric Poblems YES ____ NO ____
If yes, whom? _____

M Diabetes that requires insulin YES ____ NO ____
If yes, whom? _____

N Nerve disease (Epilepsy, Cerebral Palsy, Muscular Dystrophy) YES ____ NO ____

O Lung disease (Tuberculosis, asthma, Cystic Fibrosis) YES ____ NO ____

P Other (Explain): _____
_____

2. Have you or your husband/partner had a child by a previours marriage born with any birth defects? YES ____ NO ____
3. Do either of you have any relatives who are mentally retarded for any reason ? YES ____ NO ____
4. Is your family related by blood to your husband's/partner's family? YES ____ NO ____
5. Do you or your husband/partner have any children or relatives born with birth defects not listed above? YES ____ NO ____
If yes, indicate: _____

BOTH PARENTS

1. Are either of you black? YES ____ NO ____
If yes have you been tested for Sickle Cell disease? YES ____ NO ____
If yes, results: _____

cont...

2. Are either of you Jewish? YES ____ NO ____
3. Do you or your partner have any close relatives descended from Jewish people of Eastern or Central Europe (Ashkenazic Jews)? YES ____ NO ____
   If yes, have you been tested for Tay-Sachs disease? YES ____ NO ____
   If yes, results & who was screened : _____
4. Do you/ partner have any close relatives descended from Mediterranean countries? YES ____ NO ____
   If yes, have you been tested for Thalassemia (Cooley's Anemia)? YES ____ NO ____
   If yes, results & who was screened : _____
5. Have you or your partner ever been treated for a venereal infection (syphilis, gonorrhea, chlamydia, infection in tubes, genital Herpes, genital papillomas, condyloma or warts)? YES ____ NO ____
6. Do you have a family history of multiple births (twins, triplets)? YES ____ NO ____
7. Do you own a cat that uses a litter box? YES ____ NO ____
   If yes, does it hunt and eat raw meat, birds etc.?
8. Do you or your partner know of any genetic factors EITHER of you might be carrying which might harm your baby? YES ____ NO ____
9. Do you or your partner "do drugs" (Pot, speed, coke, acid, meth)? YES ____ NO ____

MOTHER ONLY

1. Have you had any of the conditions or illnesses listed under "FAMILY" section? YES ____ NO ____
2. Do you have trouble stopping small cuts from bleeding? YES ____ NO ____
3. Do you sweat a lot at night? YES ____ NO ____
4. Have you ever coughed up blood or been treated for tuberculosis? YES ____ NO ____
5. Have you noticed any blood in your bowel movements? YES ____ NO ____
6. Have you ever had convulsions or "fits"? YES ____ NO ____
7. Have you ever had inflammation of your leg veins (phlebitits)? YES ____ NO ____
8. Have you had German Measles? YES ____ NO ____
   If no, have you been vaccinated for German Measles? YES ____ NO ____
   If yes, where and when? _____
9. Have you ever sought or received psychiatric help? YES ____ NO ____
10. Do you smoke? YES ____ NO ____
    If yes, how many packs per day? _____
11. Do you use alacholic beverages? YES ____ NO ____
    If yes, how often and when last used? _____
12. REGARDING AIDS (HIV):
    A Have you received blood since 1977? YES ____ NO ____
    B Have you received any clotting factor concentrates (intravenous) for bleeding disorders such as Hemophilia? YES ____ NO ____
    C Have YOU ever taken illegal drugs with a needle? YES ____ NO ____
    D Have YOU ever been tested for AIDS (HIV)? YES ____ NO ____
      If yes, when _____ results _____
    E Have YOU taken or given money or drugs in return for sex (even once) since 1977? YES ____ NO ____
    F Have YOU had sex with a man you know to have taken illegal drugs with a needle OR has tested positive for AIDS (HIV) virus? YES ____ NO ____
    G Have YOU had unexplained night sweats, weight loss, persistent white patches or unusual sores in the mouth? YES ____ NO ____

cont...

H Have YOU had unexplained fever greater than 99 degrees for more than 10 days? YES ____ NO ____

I Have YOU had unexplained persistent cough, shortness or breath or persistent diarrhea? YES ____ NO ____

J Do you have any objection to being tested for AIDS (HIV) virus? YES ____ NO ____

K Do you wish to be tested for AIDS (HIV) virus with this pregnancy? YES ____ NO ____

L Has your partner had sex with anyone else since you and he have been together? YES ____ NO ____

13. DURING PREVIOUS PREGNANCIES HAVE YOU...

A Had high blood pressure ? YES ____ NO ____

B Had protein (albumin) in your urine? YES ____ NO ____

C Had convulsions? YES ____ NO ____

D Had jaundice (yellow skin)? YES ____ NO ____

E Had kidney infection? YES ____ NO ____

F Had anemia? YES ____ NO ____

G Bled excessively (hemorrhage)? YES ____ NO ____

H Required blood transfusion? YES ____ NO ____

I Broken you bag of waters before labor? YES ____ NO ____

J Have placenta in front of your baby? YES ____ NO ____

K Is there a history of a child born premature or under 5 pounds? YES ____ NO ____

L Did you ever have a child born more than 2 weeks early or 2 weeks late? YES ____ NO ____

M Is there a history of a child born weighing 9 pounds or more? YES ____ NO ____

N Were you ever hospitalized before labor? YES ____ NO ____

14. IF YOU HAD A CESAREAN DELIVERY, WAS IT FOR ANY OF THESE REASONS?

A High blood pressure or toxemia YES ____ NO ____

B Diabetes YES ____ NO ____

C Baby too large or pelvis too small YES ____ NO ____

D Labor too long or failure to progress YES ____ NO ____

E Baby in wrong position YES ____ NO ____

F Baby in difficulty YES ____ NO ____

15. AFTER ANY PREVIOUS DELIVERY DID YOU EVER HAVE THE FOLLOWING:

A Hemorrhage YES ____ NO ____

B Blood transfusion YES ____ NO ____

C Fever or infection YES ____ NO ____

D Rh injection (for RH negative mothers) YES ____ NO ____

16. Are you on any prescription medications from another doctor? YES ____ NO ____

If yes, list : _____

17. Have you taken any of those medications since your last menstrual periord? YES ____ NO ____

If yes, list and indicate date _____

_____

18. Have you taken any medicine which can be purchased over the counter in a drugstore since your last menstrual period? YES ____ NO ____

If yes, list and indicated date _____

_____

19. Have you ever been diagnosed with or treated for diabetes? YES ____ NO ____

20. Have you ever been diagnosed with or treated for thyroid problem? YES ____ NO ____

cont...

21. Do you take or have recentlt been on thyroid medication? YES ____ NO ____
22. Since your last menstrual period have you been x-rayed (dental x-rays included)? YES ____ NO ____
    If yes list dates and reasons _____
23. SINCE YOUR LAST MENSTRUAL PERIOD HAVE YOU
    - A Had frequent headaches YES ____ NO ____
    - B Had excessive nausea and vomiting YES ____ NO ____
    - C Had vaginal bleeding YES ____ NO ____
    - D Had episodes of fever YES ____ NO ____
    - E Been in close contact with persons having German Measles (Rubella) YES ____ NO ____
    - F Been in close contact with persons having Hepatitis YES ____ NO ____
    - G Used alcohol YES ____ NO ____
    - H Used drugs (cocaine, Heroin, Speed, pot, etc..) YES ____ NO ____
    - I Been injured in an accident? YES ____ NO ____
24. During the past six months have you been under the care of another physician? YES ____ NO ____
    If yes, whom and for what _____
    _____
25. Have you received any injections or vaccinations during this pregnancy? YES ____ NO ____
26. Do you now have any serious illness which might endanger this pregnancy (diabetes, sickle cell disease, heart disease, kidney disease, Herpes, asthma, Lupus etc...) YES ____ NO ____
    If yes, indicate _____
27. Have you ever had an infection in your tubes or ovaries? YES ____ NO ____
28. Have you ever had Syphilis, Gonorrhea, Chlamydia, Herpes? YES ____ NO ____
    If yes, indicate _____
29. Have you been treated for infertility or difficulity in becoming pregnant? YES ____ NO ____
30. Are you allergic to any medication(s)? YES ____ NO ____
    If yes, please list _____
    _____

I have read, understand and answered the above questions. I have also had the opportunity to ask questions or receive and explanation of anything I did not understand.

signed: _____ Date: _____