Dept. of Obstetrics
Naval Medical Center San Diego
San Diego, CA. 92134-5000

Prenatal Registration Obstetrical Questionnaire

DATE: _____

Name:	**Age:**	**Duty Station Address (Active Duty Pregnant Patient)**	**Rank:** **Duty Phone:**
Home Address:	**Home Phone:**	**Sponsor's Name:**	**Rank:**
Ethnic Origin: ☐ **Caucasian** ☐ **American Indian** ☐ **Hispanic** ☐ **Indian** ☐ **Asian** ☐ **European** ☐ **Black** ☐ **Other:**	**Occupation:**	**Sponsor's Duty Station Address:**	**Duty Phone:**
LMP: What was the <u>first day</u> of your last menstrual period? _____ **Are you ☐ certain or ☐ uncertain of this date?** **Was it ☐ normal or ☐ abnormal?** **When did you stop taking birth control pills (day, month, year)?**	**EDC**	**Gravida (# of pregnancies):** **Para (# of live births):** **Abortions: (# of miscarriages or abortions):** **# of living children at home:**	**Allergies:**

PERSONAL HISTORY

DO <u>YOU</u> HAVE A HISTORY OF OR PROBLEM WITH:	**PLEASE EXPLAIN WHEN AND OTHER IMPORTANT FACTS.**
1. GENERAL HEALTH ☐ **Obesity** ☐ **Chronic Illness** ☐ **Underweight** ☐ **Mental or physical limitations** ☐ **Poor dental condition** **What is your usual weight? _____** **What was your weight the month you got pregnant?** _____ **How Tall are you? _____**	
2. HEAD ☐ **Chronic headaches** ☐ **Migraine headaches diagnosed by a doctor** ☐ **Concussion/black-outs** ☐ **Epilepsy or seizures** ☐ **Tumors**	
ADDRESSOGRAPH CARD: **NMCSD 6320\11 (Rev 12-93)**	**PLEASE COMPLETE ENTIRE QUESTIONNAIRE AND BRING WITH YOU TO YOUR FIRST APPOINTMENT.** ***THANK YOU!!***

DO YOU HAVE A HISTORY OF OR PROBLEM WITH:	PLEASE EXPLAIN WHEN AND OTHER IMPORTANT FACTS.
3. EYES ☐ **Wear glasses or contact lens** ☐ **Blurred vision** ☐ **Poor night vision** ☐ **Blind spots or moving spots**	
4. EARS ☐ **Ear infections** ☐ **Hearing loss** ☐ **Wear hearing aids** ☐ **Ruptured ear drum**	
5. NOSE ☐ **Broken nose** ☐ **Sinus infections** ☐ **Frequent nose bleeds** ☐ **Nasal septal defect** ☐ **Nose surgery**	
6. THROAT ☐ **Tonsillitis or tonsillectomy** ☐ **Adenoidectomy** ☐ **Strep throat** ☐ **Laryngitis (loss of voice)**	
7. NECK ☐ **Lymph nodules** ☐ **Thyroid problem or surgery** ☐ **Injury from accident** ☐ **Limitation in movement**	
8. RESPIRATORY ☐ **Lung problems** ☐ **Tuberculosis (INH medications)** ☐ **Pneumonia or bronchitis** ☐ **Asthma** ☐ **+ PPD (Tuberculosis test)** ☐ **Pneumothorax (collapsed lung)**	
9. CARDIAC(HEART) ☐ **Heart disease, problems, irregular heart rate** ☐ **Hypertension (High blood pressure)** ☐ **Rheumatic heart disease** ☐ **Hypotension** ☐ **Heart murmur**	

DO YOU HAVE A HISTORY OF OR PROBLEM WITH:	PLEASE EXPLAIN WHEN AND OTHER IMPORTANT FACTS.
10. GASTRO (STOMACH) ☐ **Diabetes** ☐ **Ulcers, stomach problems** ☐ **Colitis, irritable bowel syndrome** ☐ **Chronic diarrhea** ☐ **Eating disorder – Bulimia, anorexia (starving, binging, vomiting syndrome)** ☐ **Chronic constipation** ☐ **Hemorrhoids or rectal bleeding** ☐ **Gallbladder problems** ☐ **Food poisoning** ☐ **Vegetarian**	
11. URINARY (BLADDER) ☐ **Bladder infections (UTI's)** ☐ **Kidney infection (pyelonephritis)** ☐ **Kidney stones** ☐ **Bladder or kidney surgery** ☐ **IVP's** ☐ **Leaking of urine (incontinence)**	
12. GYNECOLOGY ☐ **Problems with birth control pills** ☐ **Abnormal pap smear: dysplasia, CIN** ☐ **Colposcopy (microscopic evaluation of cervix)** ☐ **Cryosurgery (freezing of cervix)** ☐ **Cone biopsy (removal of part of the cervix)** ☐ **Infertility work up** ☐ **Painful intercourse** ☐ **Sexual molestation, abuse, rape** ☐ **Fibroid tumors** ☐ **Ovarian cysts** ☐ **Recurrent vaginitis (frequent)** ☐ **Sexually transmitted conditions:** ☐ **Trichomonas, syphilis, gonorrhea, Chlamydia** ☐ **Pelvic inflammatory disease** ☐ **Genital warts** ☐ **Miscarriage (spontaneous abortion)** ☐ **Abortions (elective abortion)** ☐ **Tubal pregnancy**	
ADDRESSOGRAPH CARD:	

DO YOU HAVE A HISTORY OF OR PROBLEM WITH:	PLEASE EXPLAIN WHEN AND OTHER IMPORTANT FACTS.
13. HEMATOLOGY (BLOOD CONDITIONS) ☐ **Bleeding tendencies** ☐ **Sickle cell or trait** ☐ **Blood clots or stroke** ☐ **Varicose veins** ☐ **Blood transfusions** ☐ **Leukemia** ☐ **Abnormal blood type (hemoglobinopathy)** ☐ **Positive antibody screen** ☐ **Hepatitis** ☐ **Anemia (low iron in blood)** ☐ **Hemorrhage** ☐ **+ HIV test/aids**	
14. LYMPHATIC SYSTEM ☐ **Abnormal lymph nodes** ☐ **Hodgkin's disease** ☐ **Erythema nodosum**	
15. MUSCULOSKELETAL ☐ **Muscle aches, pains, strains** ☐ **Broken bones or injury to muscles or bones** ☐ **Skeletal abnormalities (scoliosis)** ☐ **Birth defects or genetic deformities** ☐ **Physical restrictions in movement** ☐ **Excessive muscle aches or strains** ☐ **Carpal tunnel syndrome** ☐ **Frequently see a chiropractor**	
16. NEUROPSYCHIATRIC ☐ **Emotional problems** ☐ **Psychiatric hospitalization** ☐ **Depression or anxiety** ☐ **Childhood sexual abuse, molestation** ☐ **Have you ever seen a psychiatrist, psychologist, Or social worker?** ☐ **Marital problems**	
17. OTHER CONDITIONS ☐ **Do you smoke?** ☐ **Drink alcoholic beverages?** ☐ **Allergies to food** ☐ **Allergies to medications** ☐ **Have you ever used marijuana, speed, crack, Heroin, LSD, acid, cocaine?** ☐ **Are you taking any medications or drugs now?** ☐ **Are you exposed to any radiation risks (X-Rays)?** ☐ **Are you exposed to any environmental risks (chemical, hazardous materials at work)?** ☐ **Skin diseases, rashes?** ☐ **Do you crave (eat) unusual substances such as Starch, paint, clay, paper?**	**How much? _____** **How much? _____** **What happens? _____** **What happens? _____**

DO YOU HAVE A HISTORY OF OR PROBLEM WITH:	PLEASE EXPLAIN WHEN AND OTHER IMPORTANT FACTS.
18. CHILDHOOD ILLNESS ☐ **Chickenpox** ☐ **Measles (or received vaccine)** ☐ **Rheumatic fever** ☐ **Scarlet fever** ☐ **Mumps**	
19. OPERATIONS ☐ **Gallbladder** ☐ **Appendix** ☐ **Breast biopsy** ☐ **Breast augmentation (enlargement or reduction)** ☐ **Oral surgery** ☐ **D&C** ☐ **Plastic surgery** ☐ **Laparoscopy** ☐ **Abdominal surgery** ☐ **Any other surgery?**	
MENSTRUAL HISTORY **Age when you had your first period? _____** **Cycle length? Monthly ☐ irregular ☐** **(describe)** **Duration of bleeding? _____days** **Pain with menses/period? Yes ☐ No ☐**	

PLEASE LIST ALL PAST PREGNANCIES

DATE	WEEKS PREGNANT	VAGINAL OR C-SECTION	LENGTH OF LABOR	ANESTHESIA (PAIN RELIEF)	HOSPITAL	SEX OF BABY	WEIGHT OF BABY	COMPLICATIONS
		Vaginal				Male		
		C-Section				Female		
		C-Section				Female		
		C-Section				Female		
		C-Section				Female		
		C-Section				Female		
		C-Section				Female		
		C-Section				Female		

ADDRESSOGRAPH CARD:

CHILBIRTH QUESTIONS	YES	NO
1. Have you ever had a stillborn baby?	☐	☐
2. Have you ever had a baby with a birth defect or deformity?	☐	☐
3. Have you ever had a baby die after childbirth?	☐	☐
4. Have you ever had a premature baby (baby born earlier than 1 month before your due date)?	☐	☐
5. Have you ever had a baby with an infection after childbirth?	☐	☐
6. Have any of your babies been admitted to an intensive care unit?	☐	☐
7. Have any of your babies had jaundice?	☐	☐
8. Did you ever have hemorrhage (excessive bleeding) after any delivery?	☐	☐
9. If you are RH negative, did you receive RHOGAM with all of your pregnancies?	☐	☐
10. Were you ever hospitalized because of postpartum complications?		

PRESENT PREGANCY

Do you have any of the following now?	YES	NO	Please explain.
1. Nausea and vomiting which does not allow you to keep food or fluids down most of the time?	☐	☐	
2. Vaginal bleeding?	☐	☐	
3. Burning with urination?	☐	☐	
4. Severe abdominal pain?	☐	☐	
5. Flu, cold, measles, chickenpox, other illnesses?	☐	☐	
6. Have you taken any medications since you have been pregnant?	☐	☐	
7. Have you had any X-Rays since you have become pregnant?	☐	☐	
8. Were you taking birth control pills the month before you got pregnant? When did you stop? _____	☐	☐	
9. Did you have a pregnancy test? Was it a home pregnancy test? Yes ☐ No ☐	☐	☐	
10. Do you think you are more than 3 months pregnant right now?	☐	☐	

Please describe any medical problems or conditions which were not covered in this questionnaire which you think we need to know about you in the space below.

FAMILY HISTORY

Does any member of <u>your immediate</u> family have any of the following conditions or problems? This includes your husband and any <u>genetic diseases affecting his family.</u>

Please use the following code in the noting which family member is affected: H = Husband (father of the baby) F = father M = Mother B = Brother A = Aunt U = Uncle MGM = Maternal Grandmother PGM = Paternal Grandmother MGF = Maternal grandfather PGF = Paternal grandfather.

CONDITION (check all that apply)	PLEASE NOTE WHICH FAMILY MEMBER WAS/IS AFFECTED
1. ☐ Heart disease ☐ heart attack ☐ high blood pressure	**◉H ◉F ◉M ○B ○A ○U ◉MGM ◉PGM ○MGF ○PGF**
2. ☐ Kidney ☐ or bladder disease	**○H ○F ○M ○B ○A ○U ○MGM ○PGM ○MGF ○PGF**
3. ☐ Tuberculosis ☐ N/A	**○H ○F ○M ○B ○A ○U ○MGM ○PGM ○MGF ○PGF**
4. ☐ Diabetes ☐ N/A	**○H ○F ○M ○B ○A ○U ○MGM ○PGM ○MGF ○PGF**
5. ☐ Stroke ☐ N/A	**○H ○F ○M ○B ○A ○U ○MGM ○PGM ○MGF ○PGF**
6. ☐ Emotional or mental disorder ☐ N/A	**○H ○F ○M ○B ○A ○U ○MGM ○PGM ○MGF ○PGF**
7. ☐ Blood clots or phlebitis ☐ N/A	**○H ○F ○M ○B ○A ○U ○MGM ○PGM ○MGF ○PGF**
8. Blood variations: ☐ N/A ☐ Sickle cell disease or trait? ☐ Thalassemia? ☐ G6PD	**○H ○F ○M ○B ○A ○U ○MGM ○PGM ○MGF ○PGF**
9. ☐ Birth defects, Down's syndrome, neural tube defects ☐ N/A	**○H ○F ○M ○B ○A ○U ○MGM ○PGM ○MGF ○PGF**
10. ☐ Hemophilia ☐ N/A	**○H ○F ○M ○B ○A ○U ○MGM ○PGM ○MGF ○PGF**
11. ☐ Muscular dystrophy ☐ N/A	**○H ○F ○M ○B ○A ○U ○MGM ○PGM ○MGF ○PGF**
12. ☐ Cystic fibrosis ☐ N/A	**○H ○F ○M ○B ○A ○U ○MGM ○PGM ○MGF ○PGF**
13. ☐ Huntington chorea ☐ N/A	**○H ○F ○M ○B ○A ○U ○MGM ○PGM ○MGF ○PGF**
14. ☐ Tac-Sachs (Jewish) disease ☐ N/A	**○H ○F ○M ○B ○A ○U ○MGM ○PGM ○MGF ○PGF**
15. ☐ Twins or multiple births ☐ N/A	**○H ○F ○M ○B ○A ○U ○MGM ○PGM ○MGF ○PGF**
16. ☐ Major operations ☐ N/A	**○H ○F ○M ○B ○A ○U ○MGM ○PGM ○MGF ○PGF**
17. ☐ Cancer ☐ N/A. Describe type of cancer.	**○H ○F ○M ○B ○A ○U ○MGM ○PGM ○MGF ○PGF**
18. ☐ Chronic illnesses ☐ N/A	**○H ○F ○M ○B ○A ○U ○MGM ○PGM ○MGF ○PGF**
19. ☐ Drug abuse ☐ N/A	**○H ○F ○M ○B ○A ○U ○MGM ○PGM ○MGF ○PGF**
20. ☐ Pregnancy complications ☐ N/A	**○H ○F ○M ○B ○A ○U ○MGM ○PGM ○MGF ○PGF**
21. Did your mother take any hormones while carrying you?	**☐ Yes ☐ No**

FAMILY HISTORY COMENTS OR ADDITIONS NOT ADDRESSED ABOVE WHICH YOU FEEL WE NEED TO KNOW:

ASSESSMENT OF NUTRITIONAL STATUS

The purpose of this nutritional assessment is to determine if you need the assistance of our registered dietitian. Please answer questions 1-9 and make additional comments on the back of this page.

STATEMENT	YES	NO
1. I am taking my prenatal vitamin every day.	☐	☐
2. I skip meals or regularly go long periods without eating.	☐	☐
3. I have a history of: ☐ **gestational diabetes** ☐ **anemia** ☐ **bulimia or anorexia** ☐ **high blood pressure**		
4. I am currently having problems with the following: ☐ **nausea & vomiting** ☐ **constipation or diarrhea** ☐ **leg cramps** ☐ **heartburn** ☐ **milk allergy**		
5. I am currently: ☐ **smoking cigarettes** ☐ **equal to or under the age of 18** ☐ **craving non-food items such as clay or dirt** ☐ **following a special diet** ☐ **underweight** ☐ **overweight**		
6. I am having problems with overeating.	☐	☐
7. I am having problems with not eating enough.	☐	☐
8. I feel I need individual nutritional counseling.	☐	☐

9. PLEASE CHECK ALL THE FOODS YOU EAT REGULARLY

☐ non-fat or 1% milk	☐ fish	☐ Fruit	☐ Margarine	☐ Water
☐ low-fat milk	☐ chicken/turkey	☐ vegetables	☐ mayonnaise	☐ juice
☐ whole milk	☐ lean red meat	☐ grain cereal	☐ salad dressing	☐ soda
☐ yogurt(reg/frozen)	☐ eggs	☐ sugar cereal	☐ nuts	☐ koolaid
☐ cottage cheese	☐ beans	☐ white bread	☐ cooking oil	☐ desserts
☐ cheese	☐ hamburger	☐ wheat bread	☐ chocolate	☐ candy
☐ "creams" (ice, sour, cheese, whipped)	☐ hot dogs	☐ brown rice	☐ fast/fried foods	☐ cookies
	☐ fried chicken	☐ white rice	☐ gravy, sauces	☐ pastries

THANK YOU!

THIS SPACE FOR OFFICE USE ONLY

ADDRESSOGRAPH:

ASSESSMENT:

- ☐ **Nutritional status normal**
- ☐ **Nutritional status potential risk**
- ☐ **Schedule individual counseling appt with Registered dietitian**

Provider Signature: _____

Date: _____