HARBOUR WOMEN'S HEALTH

OBSTETRICS ● GYNECOLOGY ● UROGYNECOLOGY

Name: _____
Date of Birth: _____
Date: _____

Preconception Counseling Form

What was the first day of your last menstrual period? _____
Are your menstrual cycles regular? _____
If so, how far apart are they? _____
If not, please describe? _____
Was your last period normal (i.e. normal flow and number of days)? _____
Are you currently having any of the following symptoms (please circle):

Nausea/Vomiting	Breast Tenderness
Fatigue	Constipation
Pain w/urination	Spotting/Cramping
Dizziness/Lightheadedness	

Other: _____

When was your last pap smear? _____ Was it normal? _____
Have you ever had an abnormal pap smear? Yes/No
If so, when? _____
If so, did you have to have (please circle): Colposcopy / Leep / Cold Knife Conization

Please list any current medical problems:
_____
_____
_____
_____
_____
_____

Please list any significant previous illness or hospitalization (excluding Childbirth):
_____
_____
_____

Please list any previous surgeries or major procedures (including date):
_____
_____
_____
_____
_____

HARBOUR WOMEN'S HEALTH

OBSTETRICS ● GYNECOLOGY ● UROGYNECOLOGY

Name: _____
Date of Birth: _____
Date: _____

Please list any medical issues with the following family members and approximate age at diagnosis, if known:

Mother: _____
Father: _____
Brother (s): _____
Sister (s): _____
Children: _____
Maternal Grandmother: _____
Maternal Grandfather: _____
Paternal Grandmother: _____
Paternal Grandfather: _____
Other: _____

Please list any medications you are currently taking:

Medication	Dose	Date Started	Reason for use	Prescriber

Please list any allergies:

Medicine/Food/Latex/Environmental	Type of Reaction

If applicable, please provide the following information about previous pregnancies:

	Type of delivery: vaginal delivery, vaginal delivery assisted by forceps or vacuum, cesarean section (if miscarriage or abortion, please indicate here and leave rest of rows blank)	Date of delivery	Gestational age at delivery	Infant's gender and weight (if twins, please put both in same row)	Place of delivery	Please list any pregnancy complications
1						
2						
3						
4						
5						

HARBOUR WOMEN'S HEALTH

OBSTETRICS ● GYNECOLOGY ● UROGYNECOLOGY

Name: _____
Date of Birth: _____
Date: _____

Do you smoke? Yes / No / Quit
If yes, how many packs per day? _____ Are you interested in quitting? Yes / No
If you have quit, when? _____

Have you ever had issues with depression, including post-partum depression? Yes / No
Who lives in your home? _____
Do you have any concerns about safety in your home? Yes / No
Are there cats in your home? Yes / No
Have you had chicken pox in the past? Yes / No
Do you live with someone with tuberculosis or who has been exposed to tuberculosis? Yes / No
Have you had a rash or viral illness since your LMP? Yes / No
Do you have any history of sexually transmitted infections not including HPV? Yes / No
Have you ever had MRSA? Yes / No
When was your last flu shot? _____
Are you or the baby's father of Jewish or French Canadian Ancestry? Yes / No
What is your current occupation? _____
Do you have any potential environmental exposures you would like to discuss? Yes / No
If yes, what was the exposure _____
Have you ever had trouble with anesthesia? Yes / No
If so, please explain _____

Do you or the baby's father have a personal or family history of any of the following?

		If yes, which family member (s) is/are affected?
Thalassemia	Yes / No	
Neural tube defect (e.g. Spina bifida)	Yes / No	
Congenital heart defect	Yes / No	
Down Syndrome	Yes / No	
Tay-Sachs	Yes / No	
Canavan's Disease	Yes / No	
Sickle cell disease or trait	Yes / No	
Hemophilia or other blood disorders	Yes / No	
Muscular Dystrophy	Yes / No	
Cystic Fibrosis	Yes / No	
Huntington's Chorea	Yes / No	
Mental Retardation or Autism	Yes / No	
Fragile X	Yes / No	
Maternal metabolic disorder	Yes / No	
Recurrent pregnancy loss or stillbirth	Yes / No	
Other genetic or chromosomal disorder	Yes / No	
Other birth defect	Yes / No	