HARBOUR WOMEN'S HEALTH

OBSTETRICS ● GYNECOLOGY ● UROGYNECOLOGY

Established Patient Pregnancy Confirmation Form

Patient Name:_____
Date of Birth:_____
Date:_____

1. What was the first day of your last menstrual period? _____
2. 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)? _____
3. Are you currently having any of the following symptoms (please circle):

   Nausea/Vomiting Breast Tenderness Constipation

   Pain w/urination Spotting/Cramping Dizziness/Lightheadedness
4. Have you ever had issues with depression, including post-partum depression? Yes / No
5. Who lives in your home? _____
6. Do you have any concerns about safety in your home? Yes / No
7. Are there cats in your home? Yes / No
8. Have you had chicken pox in the past? Yes / No
9. Do you live with someone with tuberculosis or who has been exposed to tuberculosis? Yes / No
10. Have you had a rash or viral illness since your LMP? Yes / No
11. Do you have any history of sexually transmitted infections not including HPV? (gonorrhea, chlamydia, syphilis, genital herpes, trichomoniasis, hepatitis) Yes / No
12. Does your partner have a history of genital herpes? Yes / No
13. Have you ever had MRSA? Yes / No
14. Have you or your partner traveled to any areas with the Zika Virus? Yes/ No
15. Do you have any current or past use of non-prescription drug use including marijuana? Yes/No If yes which drugs?_____
16. Have you or your partner traveled to any areas with the Zika Virus? Yes/ No
17. Do you have any current or past use of non-prescription drug use including marijuana? Yes/No If yes which drugs?_____
18. When was your last flu shot? _____
19. Are you or the baby's father of Jewish, Cajun or French Canadian Ancestry? Yes / No
20. What is your current occupation? _____
21. Do you have any potential environmental exposures you would like to discuss? Yes / No

    If yes, what was the exposure _____

22. Have you ever had trouble with anesthesia? Yes / No

    If so, please explain _____

23. Any new medical diagnosis since your last visit?_____

24. Any surgeries since your last visit?_____

25. 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	
Autoimmune Disorder	Yes / No	
Hepatis / Liver Disease	Yes / No	
Other genetic or chromosomal disorder	Yes / No	
Other birth defect	Yes / No	