Stanford Children's Health
Stanford MEDICINE
Altos Oaks Medical Group

Pregnancy Intake Questionnaire

Please answer each questions to the best of your ability.
Then bring this form to your first pregnancy appointment.

Communication:

What is your Preferred language: _____

How would you rate your spoken English: □ native □ fluent □ basic □ very little

If you have difficulty with English, do you want us to discuss your care with anybody on your behalf?

If yes, please give the following information:

Name: _____

Phone number: _____

Relationship to you: _____

Other comments: _____

Your Partner or the 2nd parent of the baby:

Name: _____

How is s/he involved? □ I live with him/her □ very involved □ somewhat involved
□ involved very little □ not involved at all

Do you give permission to share information with him/her? □ Yes □ No □ Not sure

Do you have children living at home?

If yes, please list names and ages: _____

Other comments: _____

Psycho-social information:

Do you have a history of clinical depression or anxiety requiring treatment?
□ Yes □ No □ Not sure

Have you ever been sexually, physically, or emotionally abused? □ Yes □ No □ Not sure

Has your current partner ever hit, kicked, pushed or slapped you? □ Yes □ No □ Not sure

Do you feel safe at home? □ Yes □ No □ Not sure

If No, please explain: _____

I work □ Full time □ Part time □ From home □ Not at all □ Other: _____

I go to school □ Full time □ Part time □ Not at all □ Other: _____

Do you use illicit substances? □ Yes □ No □ Not sure

Have you had alcohol during this pregnancy? □ Yes □ No □ Not sure

Have you smoked cigarettes during this pregnancy? □ Yes □ No □ Not sure

Other comments: _____

over →

Current pregnancy information:

Is this pregnancy a result of IVF (in vitro fertilization)? □ Yes □ No □ Not sure

If yes, what was the transfer date: _____

and who were the donors? _____

Are you carrying twins or multiples? □ Yes □ No □ Not sure

Did you have genetic testing done for the embryo(s)? □ Yes □ No □ Not sure

If Yes, please explain: _____

Did you or the father have genetic testing done? □ Yes □ No □ Not sure

If Yes, please explain: _____

Genetic assessment:

Will you be over 35 years old at the time of the birth? □ Yes □ No □ Not sure

Will the father of the baby be over 50 years old at the time of the birth □ Yes □ No □ Not sure

Do you or the father have a family history of any of the following (check all that apply).

□ birth defects □ genetic disorders □ stillbirth □ neonatal death □ Not sure

Comments: _____

Are you or your partner of Ashkenazi Jewish ancestry? □ Yes □ No □ Not sure

If Yes, please explain: _____

Are you or your partner of African ancestry? □ Yes □ No □ Not sure

If Yes, please explain: _____

Are you or have you been exposed to chemicals or other dangers at work or home

(chemicals, paints, polishes, pesticides, lead, cats, hot baths, douching, e-rays, lifting)? □ Yes □ No □ Not sure

If Yes, please explain: _____

Infection assessment:

Do you (or anyone you live with) have travel plans during this pregnancy? □ Yes □ No □ Not sure

If Yes, please describe: _____

Did you (or anyone you live with) travel during the last 6 months? □ Yes □ No □ Not sure

If Yes, please describe: _____

Have you been exposed to TB (tuberculosis)? □ Yes □ No □ Not sure

If Yes, please explain: _____

Have you been exposed to an STI (Sexually Transmitted Infection)? □ Yes □ No □ Not sure

If Yes, please explain: _____

Have you or your partner had HSV (Herpes Simplex Virus)? □ Yes □ No □ Not sure

If Yes, please explain: _____

Have you recently been around a child with a rash? □ Yes □ No □ Not sure

If Yes, please describe: _____

Pap test information:

What is the date of your last Pap test? _____

The result was: □ Normal □ Abnormal □ Not sure Comments: _____

Have you ever had an abnormal Pap test result? □ Yes □ No □ Not sure

If yes, please explain: _____