

	Yes	No
Have you been pregnant before?	<input type="radio"/>	<input type="radio"/>
Is this an IVF pregnancy?egg donor age _____	<input type="radio"/>	<input type="radio"/>
Have you ever had a cesarean delivery?	<input type="radio"/>	<input type="radio"/>
Will you be 35 yrs or older on your due date?	<input type="radio"/>	<input type="radio"/>
Were you, the father of your baby, any of your children or any other immediate family member born with a birth defect?	<input type="radio"/>	<input type="radio"/>
Do you or an immediate family member have a genetic disorder	<input type="radio"/>	<input type="radio"/>
Have you had more than one miscarriage?	<input type="radio"/>	<input type="radio"/>
Have you ever lost a pregnancy beyond 10 weeks?	<input type="radio"/>	<input type="radio"/>
Have you ever had a preterm birth?	<input type="radio"/>	<input type="radio"/>
Have you had any vaginal spotting/bleeding in this pregnancy?	<input type="radio"/>	<input type="radio"/>
Have you ever had a cervical cone, LEEP, LEETZ or cryoablation of your cervix?	<input type="radio"/>	<input type="radio"/>
Have you used any recreational drugs during this pregnancy?	<input type="radio"/>	<input type="radio"/>
Have you consumed any alcohol during this pregnancy?	<input type="radio"/>	<input type="radio"/>
Have you smoked tobacco during this pregnancy?	<input type="radio"/>	<input type="radio"/>
Have you had any symptoms consistent with a cold or viral syndrome during this pregnancy? ...	<input type="radio"/>	<input type="radio"/>
Have you experienced nausea and vomiting (hyperemesis) during this pregnancy?	<input type="radio"/>	<input type="radio"/>
Have you had any increased swelling (edema) or excessive weight gain during this pregnancy?		
Has your weight gain has been insufficient during this pregnancy?	<input type="radio"/>	<input type="radio"/>
Have you ever taken medication for depression, anxiety or another mood disorder?	<input type="radio"/>	<input type="radio"/>
Have you experienced any joint, rib, bone or back pain during this pregnancy?	<input type="radio"/>	<input type="radio"/>
Have you experienced any lower abdominal pain since you became pregnant?	<input type="radio"/>	<input type="radio"/>
Are you taking iron or prenatal vitamins with iron for anemia?	<input type="radio"/>	<input type="radio"/>
Do you have a bleeding disorder?	<input type="radio"/>	<input type="radio"/>
Have you ever had a blood clot (pulmonary embolus or DVT)?	<input type="radio"/>	<input type="radio"/>
Do you take any prescription medication?	<input type="radio"/>	<input type="radio"/>
Have you been seen by a physician for anything other than pregnancy in the past 2 years?	<input type="radio"/>	<input type="radio"/>
Do you have:		
high blood pressure?	<input type="radio"/>	<input type="radio"/>
asthma?	<input type="radio"/>	<input type="radio"/>
diabetes?	<input type="radio"/>	<input type="radio"/>
thyroid dysfunction?	<input type="radio"/>	<input type="radio"/>
a seizure disorder?	<input type="radio"/>	<input type="radio"/>
heart problems?	<input type="radio"/>	<input type="radio"/>
kidney problems?	<input type="radio"/>	<input type="radio"/>
liver disease?	<input type="radio"/>	<input type="radio"/>
gastrointestinal problems?	<input type="radio"/>	<input type="radio"/>
autoimmune disease?	<input type="radio"/>	<input type="radio"/>

What is your height? _____ What is your weight? _____

Signature _____

Date _____