DIABLO VALLEY
PERINATAL ASSOCIATES

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

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

Signature_____ Date_____