LOS OLIVOS
WOMEN'S MEDICAL GROUP
OBSTETRICS – GYNECOLOGY – INFERTILITY

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Congratulations on your pregnancy!

The Los Olivos physicians and staff look forward to working with you during your pregnancy. Please fill out the Genetics Questionnaire and the Prenatal Questionnaire prior to your first appointment and bring them to your appointment. The first OB appointment is usually scheduled between 10 and 12 weeks of pregnancy. It is helpful if you know the first day of your last menstrual period (LMP) or when you ovulated. By tradition, the pregnancy first starts with your LMP. If you experience any problems or have any bleeding prior to the first OB appointment, please call for an earlier appointment.

Folate or folic acid, 400 mcg to 1.0 mg, should be taken each day during the first 13 weeks of pregnancy. This is included in most prenatal vitamins, which can be purchased without a prescription.

At your first obstetric visit, you will be given a copy of the Los Olivos pregnancy guide, which provides helpful information about pregnancy. The guide answers commonly asked questions and gives information on medications that can be used safely during pregnancy. You can also access this information at the Los Olivos Women's Medical Group website: www.lowmg.com. During your first prenatal appointment, the paperwork you have completed will be reviewed, your physical exam updated, and prenatal laboratory testing will be recommended. You will also be given an additional informational booklet and genetic screening and testing options will be discussed, including the California Prenatal Genetic Screening test for Trisomy 18 and 21.

Please feel free to ask any questions during any of your visits. We recommend that you write your questions down so that all of your questions can be answered. Between appointments, you may call during office hours and leave non-urgent questions on the voice mail. Your calls will be returned within 24 hours.

We are pleased that you have chosen our office for your care. In establishing a successful relationship with you, our philosophy is to work together as partners in your care towards a safe and healthy pregnancy and delivery. We strive to make this important event a wonderful and memorable experience.

The Los Olivos Physicians and Staff

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Genetics Questionnaire

Patient name:_____ Physician: _____ Date:_____

Please answer the following questions carefully at your leisure and bring the answers along with you to your first obstetrical visit. Your answers may help identify problems with your pregnancy and/or indicate special tests necessary to evaluate your health or that of your unborn baby.

Family History and Genetic screening

1. Certain genetic diseases are more common in certain ethnic groups. Please check if you or the baby's father is one of these ethnic groups.

☐ Yes ☐ No Eastern European Jewish ancestry
If yes, have you had Tay-Sachs screening tests? ☐ Yes ☐ No
If yes, have you had a Canavan screening test? ☐ Yes ☐ No

☐ Yes ☐ No African American
If yes, have you had sickle cell screening? ☐ Yes ☐ No

☐ Yes ☐ No European Ancestry
If yes, have you had cystic fibrosis screening? ☐ Yes ☐ No

☐ Yes ☐ No Mediterranean Ancestry or Southeast Asian Ancestry
If yes, have you had screening for inherited forms of anemia such as thalassemia? ☐ Yes ☐ No

2. Have you or the baby's father had a child born with a birth defect? ☐ Yes ☐ No
If yes, please describe:_____

3. Did either you or the baby's father have a birth defect? ☐ Yes ☐ No
If yes, please describe:_____

4. Please describe any abnormalities that have occurred in children of your family or the baby's father's family (eg, mental retardation, birth defects, deformities or inherited diseases such as hemophilia, muscular dystrophy, cystic fibrosis or fragile X syndrome).

_____
_____

5. Do you have any other concerns about birth defects or inherited disorders?

_____
_____

6.
☐ Yes ☐ No Will you be 35 years or older at the time the baby is born?
☐ Yes ☐ No Will the father be 50 years or older at the time the baby is born?

Please list any surgical procedure that you have had:

_____
_____
_____
_____

NAME:_____ Physician: _____

1. Have you had a temperature of 103 or greater at any time during the first two months of your pregnancy? ☐ Yes ☐ No
2. Do you own a cat? ☐ Yes ☐ No
   Who changes the litter box _____
3. Have you used any hot tubs, saunas or steam baths during this pregnancy? ☐ Yes ☐ No
4. Do you have a history of a second trimester miscarriage or an incompetent cervix? ☐ Yes ☐ No
5. Have you had problems with preterm labor during a previous pregnancy? ☐ Yes ☐ No
6. Have you been treated for infertility? ☐ Yes ☐ No
   List treatments: _____
7. Do you have any known abnormality or anomaly of your uterus? ☐ Yes ☐ No
8. Did your mother use DES when she was pregnant with you? ☐ Yes ☐ No
9. Do you and/or the baby's father have a history of herpes? ☐ Yes ☐ No
   How often do you have outbreaks/year?_____
10. Do you have a history of venereal disease, such as gonorrhea, chlamydia or HIV? ☐ Yes ☐ No
11. Have you had any abnormal pap smears? ☐ Yes ☐ No
    Dates:_____
12. Have you had a surgical procedure on your cervix such as a LEEP, or cone biopsy? ☐ Yes ☐ No
13. Do you have any close family members with tuberculosis? ☐ Yes ☐ No
14. Do you have a history of hepatitis, jaundice or liver disease? ☐ Yes ☐ No
15. Have you used cocaine, marijuana, or other drugs during this pregnancy? ☐ Yes ☐ No
16. Have you used alcohol during this pregnancy? ☐ Yes ☐ No
17. Do you smoke cigarettes? If yes, how many packs per day?_____ ☐ Yes ☐ No
18. Do you have any religious objections to any form of medical treatment (ie blood transfusions)? ☐ Yes ☐ No
19. Do you or any family member have a history of problems with anesthesia? ☐ Yes ☐ No
20. Do you have a latex allergy? ☐ Yes ☐ No
21. In the past year, have you been threatened, hit, slapped or kicked by anyone you know? ☐ Yes ☐ No
22. I have had chicken pox or have had a vaccination for it. ☐ Yes ☐ No
23. I have been vaccinated for whooping cough within the last three years. ☐ Yes ☐ No
24. I am aware of the risks to myself and my baby of using alcohol, illicit or recreational drugs and smoking during pregnancy. ☐ Yes ☐ No

List all medications taken since your last menstrual period including prescription, over-the-counter and herbal medications:

_____
_____
_____

Please list any concerns that you have:

_____
_____
_____

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Prenatal Questionnaire

LABEL

Due Date:_____ Today's Date:_____

Patient name: _____ Age: _____
Home phone: _____ Name of baby's father: _____
Your work phone: _____ Father's work phone: _____
Your cell phone:_____ Father's cell phone:_____

If there is a family history of the following conditions please check next to that condition: ☐ **NONE**

☐ Sickle cell anemia ☐ Tay Sachs ☐ Mental retardation ☐ Twins
☐ Bleeding problem ☐ Stillbirths ☐ Cystic fibrosis ☐ Thalassemia
☐ Heart defects ☐ Neural tube defects ☐ Musculodystrophy ☐ Diabetes
☐ Any hereditary problems **Please explain:**

List any illnesses in your family: ☐ None
Your partner:_____
Your mother:_____
Your father:_____
Your brothers/sisters: _____

If you have a history of the following conditions please check next to that condition: ☐ **NONE**

☐ Asthma ☐ Hepatitis ☐ Colitis ☐ Infertility ☐ Alcohol use
☐ Diabetes ☐ Herpes ☐ Heart disease ☐ Genital warts ☐ Seizure disorder
☐ Anemia ☐ Depression ☐ Fibroids ☐ Skin disorder ☐ Blood transfusion
☐ Drug use ☐ Smoking ☐ Group B streptococcus ☐ High blood pressure
☐ Thyroid disorder ☐ Frequent bladder infections ☐ Preterm labor ☐ Abnormal pap smear

Please explain any of the above check marks and list any other conditions:

List all surgeries: _____
_____
List all allergies:_____
Pregnancy history: Full term _____ Preterm_____ Twins_____
Miscarriage _____ Ectopic _____ Termination_____

Last menstrual period:_____ Was this a planned pregnancy? yes ☐ no ☐
Last contraceptive used / date last used:_____Last pap smear:_____
Date of ovulation (if known): Date of positive pregnancy test:
Any illness, x-rays or injuries during pregnancy? yes ☐ no ☐
Have you had chicken pox? yes ☐ no ☐ unsure ☐
How tall are you?_____ What is your current weight?_____ What is your pre-pregnancy weight? _____
Please list any medications used during the pregnancy. Are you taking prenatal vitamins? yes ☐ no ☐
_____
_____

Were there any complications to you or the baby during any of the pregnancies or deliveries? ☐ **NO**
_____
_____
_____

Date of delivery	Hospital	Vaginal or cesarean	Natural or epidural	Gestational age at del.	Length of labor	Weight of baby