MedStar Washington Hospital Center

Name (print): _____

Today's date: _____

Date of birth: _____

Personal Information

First date of last menstrual period (LMP): _____ or due date: _____

Height: _____ Weight: _____ Prenatal Clinic or OB provider name: _____

Marital status: ☐ Single ☐ Married ☐ Other _____

Occupation: _____

Highest level of education: _____

Race/ethnicity: ☐ Asian ☐ Black ☐ White ☐ Hispanic ☐ Other _____

Name of partner: _____ ☐ Not in relationship

Partner's race/ethnicity: ☐ Asian ☐ Black ☐ White ☐ Hispanic ☐ Other _____

Do you have any questions or concerns about today's visit? _____

Pregnancy History (All pregnancies)

☐ Never Pregnant ☐ First Pregnancy

Year of Pregnancy	Did You Have: (birth, abortion, miscarriage, ectopic)	How Did You Deliver? (vaginal, vacuum, c-section, etc.)	How Many Weeks/Months at Delivery?	Problems for Mother and/or Infant (diabetes, pre-eclampsia, fetal abnormalities, etc.)	Hospital Where Delivered	Boy or Girl?	Weight of Baby at Birth	Healthy

Allergies

☐ I have no allergies ☐ I am allergic to: ☐ shellfish ☐ iodine ☐ latex

Please list any known allergies to medications: _____

Current Medications

☐ Prenatal vitamins ☐ Iron ☐ Tylenol ☐ No medicines

Medication	Dose	Frequency (daily, etc.)

Gynecologic History

Have you had:

☐ Uterine fibroids ☐ Ovarian cysts ☐ Other, please specify: _____

☐ Infertility ☐ Abnormal Pap smear _____

☐ Cervical surgery ☐ Cervical cancer _____

Medical & Family History

☐ Check all that apply: ☐ I am adopted

Disease	Me	My Partner	Mother	Father	Brother/ sister	Other family member
NO MEDICAL PROBLEMS						
Asthma						
Autoimmune disease (lupus, rheumatoid arthritis, MS, etc.)						
Blood clots						
Blood transfusion						
Cancer (specify)						
Diabetes						
Only in pregnancy						
Heart disease						
Heart murmur						
High blood pressure						
Only in pregnancy						
HIV/AIDS						
Kidney disease						
Liver disease						
Migraines						
Miscarriages (3 or more)						
Seizures						
Sexual infections (gonorrhea, chlamydia, etc.) (list)						
Thyroid disease						
Other (list)						

Surgeries:

☐ No surgeries

Please list any surgeries (including C-sections and cervix procedures) and year:

_____

_____

_____

Lifestyle:

Do you currently:

Smoke tobacco or marijuana	☐ No	☐ Yes	Use per day _____
Use alcohol	☐ No	☐ Yes	Drinks per day _____
Use drugs	☐ No	☐ Yes	List _____

Have you or your sexual partner traveled outside of the USA in the previous 6 months?

☐ No ☐ Yes If yes, where? _____

Genetic History:

Do you, or does the father of the baby or anyone in your family, have any of the problems below?

☐ I am adopted and don't know my family history.

☐ There are no known problems in my or my family history *(If CHECKED, skip to the next section.)*

☐ Sickle cell trait/disease ☐ Muscular dystrophy

☐ Cystic fibrosis ☐ Learning disability

☐ Psychiatric illness ☐ Other disease (please list): _____

☐ Birth defects (please list): _____

_____

☐ Genetic or chromosomal condition (i.e., Down syndrome) (name): _____

For any of the above conditions, please list any affected relatives: _____

_____

Prior Genetic Testing:

Have you or the father of the baby ever had any genetic testing before?

☐ No ☐ Yes (please list): _____

Is there Jewish (Ashkenazi) ancestry in your or the father of the baby's family?

☐ No ☐ Yes (list who): _____

Are you Being Abused?

Does the person you love …

Threaten to hurt you or your children?

☐ No ☐ Yes

Throw you down, push, hit, choke, kick, or slap you?

☐ No ☐ Yes

Say it's your fault if he or she hits you, then promises it won't happen again (but it does)?

☐ No ☐ Yes

Force you to have sex when you don't want to?

☐ No ☐ Yes

Put you down in public or keep you from contacting family or friends?

☐ No ☐ Yes

Just one "yes" answer means you're involved in an abusive relationship. If so, you're not alone and you have choices.

NO ONE DESERVES TO BE ABUSED.

If you are threatened or assaulted and need emergency help, call **911**.

National 24-hour toll-free hotline numbers: **800-799-SAFE** (7233) and **800-787-3224** (TDD)

Edinburgh Depression Scale1 (EPDS)

Your date of birth: _____ Baby's date of birth: _____ Phone: _____

As you are pregnant or have recently had a baby, we would like to know how you are feeling. Please check the answer that comes closest to how you have felt **IN THE PAST 7 DAYS**, not just how you feel today.

In the past 7 days:

1. **I have been able to laugh and see the funny side of things.**
   - ☐ As much as I always could
   - ☐ Not quite so much now
   - ☐ Definitely not so much now
   - ☐ Not at all

2. **I have looked forward with enjoyment to things.**
   - ☐ As much as I ever did
   - ☐ Rather less than I used to
   - ☐ Definitely less than I used to
   - ☐ Hardly at all

3. **I have blamed myself unnecessarily when things went wrong.**
   - ☐ Yes, most of the time
   - ☐ Yes, some of the time
   - ☐ Not very often
   - ☐ No, never

4. **I have been anxious or worried for no good reason.**
   - ☐ No, not at all
   - ☐ Hardly ever
   - ☐ Yes, sometimes
   - ☐ Yes, very often

*5. **I have felt scared or panicky for no very good reason.**
- ☐ Yes, quite a lot
- ☐ Yes, sometimes
- ☐ No, not much
- ☐ No, not at all

6. **Things have been getting on top of me.**
- ☐ Yes, most of the time I haven't been able to cope at all.
- ☐ Yes, sometimes I haven't been coping as well as usual.
- ☐ No, most of the time I have coped quite well.
- ☐ No, I have been coping as well as ever.

7. **I have been so unhappy that I have had difficulty sleeping.**
- ☐ Yes, most of the time
- ☐ Yes, sometimes
- ☐ Not very often
- ☐ No, not at all

8. **I have felt sad or miserable.**
- ☐ Yes, most of the time
- ☐ Yes, quite often
- ☐ Not very often
- ☐ No, not at all

9. **I have been so unhappy that I have been crying.**
- ☐ Yes, most of the time
- ☐ Yes, quite often
- ☐ Only occasionally
- ☐ No never

*10. **The thought of harming myself has occurred to me.**
- ☐ Yes, quite often
- ☐ Sometimes
- ☐ Hardly ever
- ☐ Never

Administered/reviewed by: _____ Date: _____

[1] Source: Cox, J.L., Holden, J.M., and Sagovsky, R. 1987. Detection of postnatal depression: Development of the 10-item Edinburgh Postnatal Depression Scale. British Journal of Psychiatry 150:782-786.

[2] Source: K. L. Wisner, 8. L. Parry, C . M. Piontek, Postpartum Depression N Engl J Med vol. 347 , No 3, July 18, 2002,194-199

Thank you for taking time to complete this questionnaire.

Please return it to the receptionist once completed.

We look forward to serving you.

16-MWHC-2883.092016