

PRECONCEPTION SCREENING AND COUNSELING CHECKLIST

NAME	BIRTHPLACE	AGE
DATE: / / __N		ARE YOU PLANNING TO GET PREGNANT IN THE NEXT SIX MONTHS? __ Y
IF YOUR ANSWER TO A QUESTION IS YES, PUT A CHECK MARK ON THE LINE IN FRONT OF THE QUESTION. FILL IN OTHER INFORMATION THAT APPLIES TO YOU		

DIET & EXERCISE

What do you consider a healthy weight for you? _____

___ Do you eat three meals a day?

___ Do you follow a special diet (vegetarian, diabetic, other)?

___ Which do you drink (___ coffee ___ tea ___ cola ___ milk ___ water ___ other soda/pop other _____)?

___ Do you eat raw or undercooked food (meat, other)?

___ Do you take folic acid?

___ Do you take other vitamins daily (___ multivitamin ___ vitamin A ___ other)?

___ Do you take dietary supplements (___ black cohosh ___ pennyroyal ___ other)?

___ Do you have current/past problems with eating disorders?

___ Do you exercise? Type/frequency: _____

Notes:

LIFESTYLE

___ Do you smoke cigarettes or use other tobacco products?

How many cigarettes/packs a day? _____

___ Are you exposed to second-hand smoke?

___ Do you drink alcohol?

What kind? _____ How often? _____ How much? _____

___ Do you use recreational drugs (cocaine, heroin, ecstasy, meth/ice, other)?

List: _____

___ Do you see a dentist regularly?

What kind of work do you do? _____

___ Do you work or live near possible hazards (chemicals, x-ray or other radiation, lead)? List: _____

___ Do you use saunas or hot tubs?

NOTES:

MEDICATION/DRUGS

___ Are you taking prescribed drugs (Accutane, valproic acid, blood thinners)? List them _____

___ Are you taking non-prescribed drugs?

List them: _____

___ Are you using birth control pills?

___ Do you get injectable contraceptives or shots for birth control?

___ Do you use any herbal remedies or alternative medicine?

List: _____

NOTES:

MEDICAL/FAMILY HISTORY

Do you have or have you ever had:

___ Epilepsy?

___ Diabetes?

___ Asthma?

___ High blood pressure?

___ Heart disease?

___ Anemia?

___ Kidney or bladder disorders?

___ Thyroid disease?

___ Chickenpox?

___ Hepatitis C?

___ Digestive problems?

___ Depression or other mental health problem?

___ Surgeries?

___ Lupus?

___ Scleroderma?

___ Other conditions?

Have you ever been vaccinated for:

___ Measles, mumps, rubella?

___ Hepatitis B?

___ Chickenpox?

NOTES:

WOMEN'S HEALTH

___ Do you have any problems with your menstrual cycle?

___ How many times have you been pregnant?

What was/were the outcomes(s)? _____

___ Did you have difficulty getting pregnant last time?

___ Have you been treated for infertility?

___ Have you had surgery on your uterus, cervix, ovaries or tubes?

___ Did your mother take the hormone DES during pregnancy?

___ Have you ever had HPV, genital warts or chlamydia?

___ Have you ever been treated for a sexually transmitted infection (genital herpes, gonorrhea, syphilis, HIV/AIDS, other)? List: _____

NOTES:

GENETICS

Does your family have a history of _____ or _____ your partner's family

___ Hemophilia? _____

___ Other bleeding disorders? _____

___ Tay-Sachs disease? _____

___ Blood diseases (sickle cell, thalassemia, other)? _____

___ Muscular dystrophy? _____

___ Down syndrome/Mental retardation? _____

___ Cystic fibrosis? _____

___ Birth defects (spine/heart/kidney)? _____

Your ethnic background is: _____

Your partner's ethnic background is: _____

NOTES:

HOME ENVIRONMENT

___ Do you feel emotionally supported at home?

___ Do you have help from relatives or friends if needed?

___ Do you feel you have serious money/financial worries?

___ Are you in a stable relationship?

___ Do you feel safe at home?

___ Does anyone threaten or physically hurt you?

___ Do you have pets (cats, rodents, exotic animals)? List: _____

___ Do you have any contact with soil, cat litter or sandboxes?

Baby preparation (if planning pregnancy):

___ Do you have a place for a baby to sleep?

___ Do you need any baby items?

NOTES:

OTHER

IS THERE ANYTHING ELSE YOU'D LIKE ME TO KNOW?

ARE THERE ANY QUESTIONS YOU'D LIKE TO ASK ME?