PRECONCEPTION SCREENING AND COUNSELING CHECKLIST

NAME	BIRTHPLACE	AGE

DATE: / / ARE YOU PLANNING TO GET PREGNANT IN THE NEXT SIX MONTHS? __ Y __N

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:

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:

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 you 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:

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:

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:

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:

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:

OTHER

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

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