

PRECONCEPTION SCREENING AND COUNSELING CHECKLIST

Name: _____

Country of Birth: _____

Age: _____

Date: _____

Are you planning on becoming pregnant in the next six months? YES NO
(IF YES, PLEASE COMPLETE THE REMAINDER OF THIS FORM)

Are you currently using any family planning methods? YES NO

DIET & EXERCISE

Please complete:

What is your current weight? _____

What is your current height? _____

Do you eat three meals per day? YES NO

Do you follow a special diet (vegetarian, diabetic, other?) YES NO

How many glasses of the following do you drink each day?

Coffee _____ Tea _____

Cola _____ Milk _____

Water _____ Other _____

Do you eat raw or undercooked food (meat, other)? YES NO

Do you take Folic Acid daily? YES NO

Do you take other vitamins daily? YES NO

Do you have current or past problems with an eating disorder? YES NO

Do you exercise regularly? YES NO
Type/Frequency _____

TEACHING POINT:

- Work toward a healthy weight by exercising on a regular basis.
- All women of childbearing age should take a multivitamin that contains folic acid. Folic acid reduces the chance of certain birth defects, especially when it is taken BEFORE you become pregnant.
- Talk to your health care provider if you are on a special diet.

MEDICATION/DRUGS

Are you taking any of the following:

Prescribed drugs (Accutane, Valproic Acid, blood thinners, pain medication)? YES NO
Please list: _____

Anxiety or depression medications? YES NO
Please list: _____

Over-the-counter medications (Tylenol, Motrin, allergy meds)? YES NO
Please list: _____

Herbal remedies or alternate medicine (Acupuncture, massage)? YES NO
Please list: _____

TEACHING POINT:

Talk to your health care provider about ALL of the medications and herbal remedies you are taking. Some may need to be stopped prior to becoming pregnant.

WOMEN'S HEALTH

Date of last pap smear: _____

Do you have any problems with your menstrual cycle? YES NO

Explain: _____

How many times have you been pregnant?

Full-term babies _____

Preterm babies _____

Any babies in intensive care nursery? _____

When was your last pregnancy? _____

Did you have difficulty getting pregnant last time? YES NO

Have you been treated for infertility? YES NO

Have you had surgery on your uterus, cervix, ovaries, tubes, LEEP? YES NO

Explain: _____

Did your mother take DES during pregnancy? YES NO

Have you ever had HPV, genital warts or Chlamydia? YES NO

Explain: _____

Have you ever been treated for a sexually transmitted infection (genital herpes, gonorrhea, syphilis, HIV/AIDS, other)? YES NO

Explain: _____

Have you ever been tested for HIV? YES NO

If yes, when: _____

TEACHING POINT:

If you have not been tested for HIV within the past three years, talk to your health care provider about being tested.



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HOME ENVIRONMENT

Do you/Are you:

- Feel emotionally supported at home? YES NO
- Have help from relatives and/or friends? YES NO
- Feel you have serious money/financial worries? YES NO
- In a stable relationship? YES NO
- Feel safe at home? YES NO
- Does anyone threaten or physically hurt you? YES NO
- Have pets? YES NO
- Have any contact with soil, cat litter or sandboxes? YES NO

If planning pregnancy:

- Do you have a place for a baby to sleep? YES NO
- Do you need any baby items? YES NO

LIFESTYLE:

- Do you smoke cigarettes or use tobacco products? YES NO
How many cigarettes/packs a day? _____
- Are you exposed to secondhand smoke? YES NO
- Do you drink alcohol? YES NO
How often: _____ How much: _____
- Do you use recreational/street drugs (Cocaine, Heroin, Ecstasy, Meth/Ice, Marijuana or pain pills)? YES NO
List: _____
How often: _____
- Have you been or are you being treated for alcohol/substance abuse? YES NO
- Do you see a dentist regularly? YES NO
- What type of work do you do? _____
- Do you work or live near possible hazards (lead, chemicals, X-ray/radiation)? YES NO
Explain: _____
- Do you use saunas or hot tubs? YES NO

MEDICAL/FAMILY HISTORY

Do you have or have you ever had:

- Epilepsy/Seizures? YES NO
- Chickenpox? YES NO
- Diabetes? YES NO
- Hepatitis C? YES NO
- Asthma? YES NO
- Digestive problems? YES NO
- Tuberculosis? YES NO
- Depression or other mental health problems? YES NO
- High blood pressure? YES NO
- Surgeries? YES NO
List: _____

- Heart disease? YES NO
- Lupus? YES NO
- Anemia? YES NO
- Multiple sclerosis? YES NO
- Kidney or bladder disorder? YES NO
- Scleroderma? YES NO
- Thyroid disease? YES NO
- Other conditions? _____

Have you ever been vaccinated for:

- Measles, Mumps, Rubella? YES NO
- TDAP? YES NO
- Hepatitis B? YES NO
- Chickenpox? YES NO
- Human Papilloma Virus (HPV)? YES NO
- Flu vaccine? YES NO

GENETICS:

Do you or your family or partner's family have a history of:

- Hemophilia? YES NO
Who? _____
- Bleeding disorders? YES NO
Who? _____
- Tay-Sachs disease? YES NO
Who? _____
- Blood disease (Sickle Cell, Thalassemia, other)? YES NO
Who? _____
- Muscular Dystrophy? YES NO
Who? _____
- Down Syndrome/Mental retardation? YES NO
Who? _____
- Cystic Fibrosis? YES NO
Who? _____
- Phenylketonuria (PKU)? YES NO
Who? _____
- Birth defects (spine, heart, kidney)?
Who? _____
- Your ethnic background is: _____
- Your partner's ethnic background is: _____



Created by the WNY Prenatal Collaborative

OFFICE USE ONLY:

- Is a follow up appointment needed? YES NO