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.

Created by the WNY Prenatal Collaborative

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: _____

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Created by the WNY Prenatal Collaborative

OFFICE USE ONLY:
Is a follow up appointment needed? ☐ **YES** ☐ **NO**