PERINATAL CENTER AT UNITYPOINT HEALTH

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Thank you for choosing Perinatal Center!
We're happy to be part of your health care team.
To get started, please take a few minutes to fill out the enclosed forms.

Preconception Questionnaire Instructions

- ✓ Fill out the health and obstetrical history completely and return to Perinatal Center via mail or upload to the patient portal. ***This will initiate your referral review.***

- ✓ Sign included 'release of information' form to return with your packet for any records outside UnityPoint Health that will help with your consultation.
  *Please fill out one form per office - you may copy release form or contact us for more forms if needed.

- ✓ We will notify you when we have received your packet. When we receive your paperwork and any applicable records, our team will review and prepare for your consultation.

- ✓ You will be contacted by a nurse if we have any follow up questions or need more information, otherwise you will be contacted once we are ready to schedule your preconcept appointment.

- ✓ Please call our office if you become pregnant prior to your appointment as that will require a different type of appointment to be scheduled.

Demographics **Preconception Information** **Date:** _____

Name: _____ Date of Birth: _____ Age: _____
Address: _____ Phone: _____

Check box: ☐ Married ☐ Single ☐ Engaged ☐ Partner ☐ Divorced ☐ Widowed
Partner's name: _____ Ph. #:_____

Referring provider: _____ Preferred language: _____
Reason preconception consult requested (Specify what we will be discussing prior to a pregnancy):

_____
When do you plan to conceive? _____
Are you currently using contraception? ☐ Yes - type: _____ ☐ No

Caffeine use: ☐ None/rarely ☐ Occasional ☐ Daily _____#servings/day
Tobacco use/Vape: ☐ Never ☐ Current _____# cigarettes/day ☐ Former; Quit date: _____

Obstetrical/Gynecological History

First day of last period: _____ Have you been pregnant before? Yes☐ No☐ *if "No" skip to Medical History*
Have you had fetal loss past 20 weeks gestation? Yes☐ No☐

Please list all pregnancies, including miscarriages, abortions and ectopic pregnancies.

Birthdate	Weeks	Weight	Delivery Type (C/S, Vaginal, VBAC)	Boy/Girl	Living	Complications	Location (Hosp/City/State)
				Boy/Girl	Y - N		
				Boy/Girl	Y - N		
				Boy/Girl	Y - N		
				Boy/Girl	Y - N		
				Boy/Girl	Y - N		
				Boy/Girl	Y - N		
				Boy/Girl	Y - N		

Additional comments: _____
_____
Have you ever had a cervical or abdominal cerclage or pessary? _____
Have you ever been on progesterone/makena for history of preterm delivery? _____

Medical History – Check all applicable, add on if not listed below.

☐	Allergies	☐	Depression	☐	Infertility	☐	STD
☐	Asthma	☐	Diabetes Type 1	☐	High Blood Pressure	☐	Thyroid disease
☐	Anxiety	☐	Diabetes Type 2	☐	High Cholesterol	☐	Weight loss surgery
☐	Autoimmune disorder	☐	Fibroids	☐	Kidney disease	☐	
☐	Bleeding disorder	☐	GERD	☐	Liver disease	☐	
☐	Blood transfusion	☐	Gestational Diabetes	☐	Migraines	☐	
☐	Cancer _____	☐	Heart disease	☐	Preeclampsia	☐	
☐	DVT/PE/Blood clot	☐	Hepatitis A/B/C	☐	Seizures	☐	

Additional comments: _____
_____
_____

Name: _____ DOB: _____

Surgical History Please list all surgeries including any gynecological surgeries or procedures with dates:

_____
_____
_____
_____
_____

Allergies List any allergies and reaction

_____
_____
_____
_____
_____

Current Medications List any prescription and nonprescription medications, include dosages

1.	4.
2.	5.
3.	6.

Family History (Please check for immediate family members)

Illness	Mother	Father	Siblings	Maternal Grandmother	Maternal Grandfather	Paternal Grandmother	Paternal Grandfather	Other
Cancer								
Congenital Heart Disease								
DVT/PE/Blood clot								
High Blood Pressure								
Thyroid Disease								
Diabetes								
Heart Disease								
Kidney Disease								
Genetic Defects								
Other								

Genetic Screening

Do you or your partner have a family history of any of the following?

- ☐ Congenital heart disease
- ☐ Facial clefts
- ☐ Neural tube defects (open spine, spina bifida, anencephaly)
- ☐ Down Syndrome
- ☐ Sickle Cell disease or trait
- ☐ Hemophilia
- ☐ Muscular Dystrophy
- ☐ Cystic Fibrosis
- ☐ Huntington Chorea
- ☐ Mental retardation, Fragile X
- ☐ Any inherited genetic or chromosomal disorder, please describe:

  _____

- ☐ Have you or your partner had a child with a birth defect not listed above?

  _____

  If yes to above, have you received any genetic counseling/testing? ☐No ☐Yes (location) _____
  If you have had any testing, please include a copy of your results.

Any specific questions that you would like the provider to cover? _____

_____

_____