Stanford Children's Health
Stanford MEDICINE

Pregnancy Intake Questionnaire

Please answer each questions to the best of your ability.
Then bring this form to your first pregnancy appointment.

Communication:

What is your Preferred language: _____

How would you rate your spoken English: □ native □ fluent □ basic □ very little

If you have difficulty with English, do you want us to discuss your care with anybody on your behalf?

If yes, please give the following information:

Name: _____

Phone number: _____

Relationship to you: _____

Other comments: _____

Your Partner or the 2nd parent of the baby:

Name: _____

How is s/he involved? □ I live with him/her □ very involved □ somewhat involved
□ involved very little □ not involved at all

Do you give permission to share information with him/her? □ Yes □ No □ Not sure

Do you have children living at home?

If yes, please list names and ages: _____

Other comments: _____

Psycho-social information:

Do you have a history of clinical depression or anxiety requiring treatment?
□ Yes □ No □ Not sure

Have you ever been sexually, physically, or emotionally abused? □ Yes □ No □ Not sure

Has your current partner ever hit, kicked, pushed or slapped you? □ Yes □ No □ Not sure

Do you feel safe at home? □ Yes □ No □ Not sure

If No, please explain: _____

I work □ Full time □ Part time □ From home □ Not at all □ Other: _____

I go to school □ Full time □ Part time □ Not at all □ Other: _____

Do you use illicit substances? □ Yes □ No □ Not sure

Have you had alcohol during this pregnancy? □ Yes □ No □ Not sure

Have you smoked cigarettes during this pregnancy? □ Yes □ No □ Not sure

Other comments: _____

over →

Current pregnancy information:

Is this pregnancy a result of IVF (in vitro fertilization)? □ Yes □ No □ Not sure

If yes, what was the transfer date: _____

and who were the donors? _____

Are you carrying twins or multiples? □ Yes □ No □ Not sure

Did you have genetic testing done for the embryo(s)? □ Yes □ No □ Not sure

If Yes, please explain: _____

Did you or the father have genetic testing done? □ Yes □ No □ Not sure

If Yes, please explain: _____

Genetic assessment:

Will you be over 35 years old at the time of the birth? □ Yes □ No □ Not sure

Will the father of the baby be over 50 years old at the time of the birth □ Yes □ No □ Not sure

Do you or the father have a family history of any of the following (check all that apply).

□ birth defects □ genetic disorders □ stillbirth □ neonatal death □ Not sure

Comments: _____

Are you or your partner of Ashkenazi Jewish ancestry? □ Yes □ No □ Not sure

If Yes, please explain: _____

Are you or your partner of African ancestry? □ Yes □ No □ Not sure

If Yes, please explain: _____

Are you or have you been exposed to chemicals or other dangers at work or home

(chemicals, paints, polishes, pesticides, lead, cats, hot baths, douching, e-rays, lifting)? □ Yes □ No □ Not sure

If Yes, please explain: _____

Infection assessment:

Do you (or anyone you live with) have travel plans during this pregnancy? □ Yes □ No □ Not sure

If Yes, please describe: _____

Did you (or anyone you live with) travel during the last 6 months? □ Yes □ No □ Not sure

If Yes, please describe: _____

Have you been exposed to TB (tuberculosis)? □ Yes □ No □ Not sure

If Yes, please explain: _____

Have you been exposed to an STI (Sexually Transmitted Infection)? □ Yes □ No □ Not sure

If Yes, please explain: _____

Have you or your partner had HSV (Herpes Simplex Virus)? □ Yes □ No □ Not sure

If Yes, please explain: _____

Have you recently been around a child with a rash? □ Yes □ No □ Not sure

If Yes, please describe: _____

Pap test information:

What is the date of your last Pap test? _____

The result was: □ Normal □ Abnormal □ Not sure Comments: _____

Have you ever had an abnormal Pap test result? □ Yes □ No □ Not sure

If yes, please explain: _____