LIFELINE MEDICAL ASSOCIATES, LLC

WOMEN'S HEALTHCARE IS OUR LIFE'S WORK.

COMPREHENSIVE CARE CENTER

Name: _____ Today's Date: _____

DOB: _____

The following questionnaire is a screening tool used to assist your provider in determining if there are any preconception risk factors present. Please answer all questions to the best of your ability.

	YES	NO	UNSURE
Have you had Chicken Pox?			
Have you had a flu shot this year?			
Are you up-to-date on your immunizations?			
Have you ever taken or are you currently taking Accutane?			
Do you have a history of depression and/or anxiety?			
Are your menses regular? (Roughly 28 days apart)			
Have you ever been pregnant?			
Are you currently using any form of contraception?			
Do you now or have you ever had any serious medical conditions (ie diabetes or epilepsy)?			
Do you have a history of pregnancy-related problems (ie. two or more miscarriages, very low birth weight babies, preterm labor)?			
Do you or your partner have a history of, or are you at risk of, infectious disease (ie sexually transmitted, or from contact with blood)?			
Are you on a special diet? (ie: vegetarian, diabetic, low-fat, etc.)			
Do you drink more than 2 cups of coffee per day?			

Do you or your partner smoke or use tobacco products?			
Do you or your partner drink alcohol?			
Do you or your partner use recreational drugs? (ie: cocaine, speed, marijuana, etc)			
Are you or your partner exposed to chemicals, radiation, or infections at work?			
Do you own or work with cats?			
Have you ever been physically, emotionally, or sexually abused?			
Do you live with someone who is abusive?			
Do you or your partner have a family history of birth defects or hereditary disorders?			
Are you a "carrier" of a genetic condition (sometimes called having a "trait") such as Cystic Fibrosis, Sickle Cell Anemia, or Thalassemia)?			
Do you or your partner have any Jewish Ancestry?			
Are you and the potential father blood-related?			

1. Please describe what you had for breakfast, lunch, dinner, and snack yesterday? Please Include times.
   B: _____
   L: _____
   D: _____
   S: _____
2. Which of the following describes your exercise routine?
   - ❑ Exercise physically impossible
   - ❑ Avoid even trivial exercise
   - ❑ Do light exercise
   - ❑ Do moderate exercise
   - ❑ Do heavy exercise
   - ❑ Competitive athlete
3. When was your last menstrual period? _____
4. When was your last Tdap vaccine? _____
5. What race and ethnicity do you and your partner identify with? Check all that apply.
   - ❑ American Indian or Alaska Native
   - ❑ Asian
   - ❑ Black/African American
   - ❑ Hispanic or Latino
   - ❑ Middle Eastern
   - ❑ Native Hawaiian or Other Pacific Islander
   - ❑ Other
   - ❑ White
   - ❑ Declined to Specify