Mercy Maternal and Fetal Health Center
615 S. New Ballas Rd. | St. Louis, MO 63141 | Fax: 314-251-4995

Mercy Clinic Maternal Fetal Health
621 S. New Ballas Rd. | Suite2007B | St. Louis, MO 63141 | Fax: 314-991-5035

Patient Demographics Questionnaire

Name: _____ **Date:** _____

DOB:___ / ___ / ___ Age:_____ Height: _____ Weight:_____

Referring/Delivering Physician: _____

Reason for your visit: _____

PREGNANCY DATING

_____ Last Menstrual Period Date: ____ / ____ / ____ ☐ Unsure
_____ Normal Cycles: ☐ Yes ☐ No
_____ Conception Date (if known): _____
_____ Due Date assigned by your doctor: _____
_____ Ultrasound(s) this pregnancy: ☐ Yes ☐ No How many? _____
_____ Was your due date determined by ultrasound? ☐ Yes ☐ No
_____ IVF or any other assistance to achieve pregnancy

ALLERGIES

Latex Allergy: ☐ Yes ☐ No
If Yes, please describe your reaction to Latex:_____
Medication Allergies: ☐ Yes ☐ No
Name of Medication **Reaction:** (*itching, rash, trouble breathing, hives, etc.*)
_____
_____
_____
Food Allergies: ☐ Yes ☐ No

HISTORY		
☐ No significant history	☐ Cervical and Uterine	☐ Infertility treatments:
☐ Hyperemesis (*extreme vomiting during pregnancy*)	☐ Abnormal pap	☐ Clomid
☐ High Blood Pressure	☐ Uterine fibroids	☐ IVF (in-vitro fertilization)
☐ During pregnancy	☐ Mental Health Concerns	☐ IUI (intrauterine insemination) or ovulation induction
☐ When not pregnant	☐ Anxiety	☐ ICSI (intracytoplasmic sperm injection)
☐ Liver Disease	☐ Depression	☐ Sexually transmitted disease
☐ Asthma	☐ Seizures/Epilepsy	☐ Chlamydia
☐ Autoimmune Disorder	☐ Sickle Cell Disease	☐ Gonorrhea
☐ Arthritis	☐ Kidney Disease	☐ Herpes
☐ Lupus	☐ Thyroid Problems	☐ Genital Warts
☐ Other:	☐ Blood Clots/Deep Vein Thrombosis	☐ Syphilis
☐ Diabetes	☐ Clotting Disorders	☐ HIV/AIDS
☐ Diabetes – Gestational	☐ Factor V Leiden	☐ Hepatitis
☐ Heart Disease or Heart Problems:	☐ Antiphospholipid antibody syndrome	☐ Cancer
		☐ Type:
☐ Other (*Please describe*):		

SURGICAL HISTORY		
☐ No Previous Surgery	☐ Treatment for Abnormal Pap: ☐ Laser ☐ Freezing ☐ LEEP ☐ Conization	
☐ Amniocentesis	☐ Cervical Cerclage	☐ Blood Transfusion
☐ Appendectomy	☐ Surgery on the Uterus	☐ Breast Implants or other Breast Surgery
☐ D&C	☐ Gall Bladder removal	☐ Tubal Ligation/Sterilization
☐ Lumpectomy for Cancer	☐ Others:	

SUBSTANCE USE		
	Yes–describe:	No
Tobacco Use		
Alcohol Use		
Drug Use		

**** Questionnaire continues on reverse side***

PATIENT IDENTIFICATION

PREGNANCY HISTORY (*live births, miscarriages and abortions*)									
MM/YY	Weeks at Delivery	Baby's Birth Weight	Vaginal or C-Section	Sex	Preterm Labor	Gestational Diabetes	High Blood Pressure	Birth Defects	Complications
					Y / N	Y / N	Y / N		
					Y / N	Y / N	Y / N		
					Y / N	Y / N	Y / N		
					Y / N	Y / N	Y / N		
					Y / N	Y / N	Y / N		
					Y / N	Y / N	Y / N		
	☐ Miscarriage ☐ Missed Abortion ☐ Elective Abortion ☐ Ectopic ____ wks pregnant ☐ with D&C ☐ without D&C								
	☐ Miscarriage ☐ Missed Abortion ☐ Elective Abortion ☐ Ectopic ____ wks pregnant ☐ with D&C ☐ without D&C								
	☐ Miscarriage ☐ Missed Abortion ☐ Elective Abortion ☐ Ectopic ____ wks pregnant ☐ with D&C ☐ without D&C								
Office Use Only: ☐ Gravida ☐ Para ☐ Term ☐ Preterm ☐ AB ☐ Living Gestation at this visit: ☐ w ☐ d									

CURRENT MEDICATIONS (*Please include all prescription and over-the-counter medications, vitamins, herbals, and supplements that you are* **currently** *taking*)			
Name of Medication	**Dosage**	**Name of Medication**	**Dosage**

SCREENINGS:		
Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Widowed ☐ Legally Separated		
☐ Significant Other: Partner's first name:	Partner's race/ethnic background:	
Planned hospital for preterm birth or pregnancy complications:		
Planned hospital for term birth:		
PAIN	**NUTRITION SCREEN**	
Pain rating:	☐ Special/restrictive diet:	☐ No issues or concerns
Location of pain:	☐ Other	

ABUSE/NEGLECT/DOMESTIC VIOLENCE		
Yes	No	Are you a victim of verbal, physical, emotional, or sexual abuse?
FUNCTIONAL STATUS		
Yes	No	Do you need help or equipment to assist you with daily activities?
RISK		
Yes	No	Are you having thoughts of hurting yourself or others?
FALLS		
Yes	No	Have you fallen in the last 3 months?
Yes	No	Are you experiencing dizziness?
Yes	No	Are you experiencing weakness?
Yes	No	Are you experiencing difficulty walking?

FAMILY HISTORY			
	Yes–describe:	Relationship	No
Chromosomal problems			
Mental retardation			
Birth defects			
Genetic disorders			

Have you had any screening for Down Syndrome and/or spina bifida in this pregnancy? ☐ No ☐ Yes, *please circle*

1st trimester Screening Nuchal translucency **Protein Tests:** Quad Screen Penta Screen **NIPT:** Panorama Harmony Qnatal ClariTest

Signature of RN verifying information and entering into Epic: _____ **Date entered:** _____