The Valley Hospital
Valley Health System

Maternal Fetal Medicine Patient Questionnaire

Dr. Gail Matthews Dr. Traci Burgess Dr. Carolyn Zelop Dr. Claudia Mosquera Dr. Jane Goldman Dr. Jennifer Amorosa

Please complete the following: Height:_____ Weight:_____

Latex Allergy: ☐ Yes ☐ No

Name:_____ Date of Appointment: _____

Name of your Doctor's Group: _____

Name of your Doctor: _____

Race/Ethnic background: ☐ Asian ☐ African American ☐ Caucasian ☐ Hispanic ☐ Other

_____

First day of your last menstrual period:_____ Due Date:_____

Did you have screening/testing for chromosomal or genetic abnormalities?

First Trimester Nuchal Translucency	☐ Yes	☐ No	
16 Week Sequential	☐ Yes	☐ No	comments:_____
Cellfree DNA	☐ Yes	☐ No	_____
Amnio	☐ Yes	☐ No	_____
CVS	☐ Yes	☐ No	_____

_____

OBSTETRICAL HISTORY:

Total number of times you were pregnant including this pregnancy _____

Total number of full term deliveries (37 weeks or more) _____

Total number of premature deliveries _____ How pregnant were you? _____

Total number of abortions _____ miscarriages _____ ectopic pregnancies_____

Total number of living children _____

Were any of your deliveries by Cesarean section? θ Yes θ No If yes, how many? _____

CURRENT PREGNANCY:

In-Vitro Fertilization: ☐ Yes ☐ No ICSI: ☐ Yes ☐ No PGD: ☐ Yes ☐ No

Donor Egg: ☐ Yes ☐ No If yes, age of donor _____ IUI: ☐ Yes ☐ No

MEDICAL HISTORY:

LEEP Procedure or Cone Biopsy	☐ Yes	☐ No Year_____	Diabetes	☐ Yes	☐ No
Heart Disease	☐ Yes	☐ No	Abnormal Thyroid Function	☐ Yes	☐ No
High Blood Pressure	☐ Yes	☐ No	Other_____		

Comments: _____

Current medications _____

_____

Have you experienced any complications, birth defects or chromosomal abnormalities with previous pregnancies? Please explain:_____

_____

_____