NORTHSIDE MATERNAL HEART HEALTH CENTER
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NEW PATIENT PREECLAMPSIA HEALTH SCREENING QUESTIONNAIRE

Please complete this form prior to your visit as doing so will be of assistance to us in providing you with an excellent standard of care.

Patient Name: _____ **DOB:** ____-____-____

E-Mail Address: _____ **How were you referred to our practice?** _____

PCP name: _____ **OB/ GYN or Other is referring M.D:** _____

Ethnic Origin: _____

PRESENT MEDICAL STATUS

Is this your first pregnancy? ◎ Yes ◎No How many times have you been pregnant? _____

Are you currently pregnant? ◎ Yes ◎No Gestation (weeks): ___ ◎ Single ◎ Multiple:

Pre-Pregnancy weight in lbs: _____ Present weight: _____ Are you presently breast feeding: ◎ Yes ◎No

Are you planning a pregnancy? ◎ Yes ◎No via ◎ IVF Have you had any fertility treatments? ◎ Yes ◎ No

How many deliveries? ◎ Full Term: _____ ◎ Pre-Term: _____ Method of delivery: ◎ Vaginal: ___ ◎ C-Section: _____

If the delivery was not to Full Term, please explain why not? _____ Delivery dates: __/__/__ __/__/__

How many were ◎ Live births: _____ ◎Not survived: _____ Did the same male father each pregnancy? ◎ Yes ◎ No

Have you received medical supervision in relationship to your present condition? ◎ Yes ◎No

If yes, when? _____ Where? _____ Name/ Type of specialist: _____

CARDIAC RISK FACTORS

Are any of the following applicable to you presently (please check/ bubble your response).

High Blood Pressure: ◎ Yes, If yes, how long? ___ ◎No Are you taking Blood Pressure meds? ◎ Yes ◎No

Diabetes: ◎ Yes, If yes, __ Gestational __ Not Pregnant ◎No Have you had a recent Hemoglobin A1C? ◎ Yes ◎No

High Cholesterol (Hyerlipidemia): ◎ Yes ◎No Do you know your values? __ Total Cholesterol __ LDL

Do you have a family history of Pre-Eclampsia: ◎ Yes ◎No Heart attack younger than 55 y/o? ◎ Yes ◎No

Do you smoke: ◎ Yes, -- if yes, how many packs per day? _____ ◎No ◎ Quit: _____ (yr)

Do you exercise: ◎ Yes, if yes, how often? ____ ◎No Are you currently using contraception? ◎ Yes ◎No

What method of contraception is being used: _____

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PAST MEDICAL HISTORY

Are any of the following applicable to you presently and/ or past (check/ bubble your response); also list conditions that are not below.

◎ Heart Attack ◎ Heart Murmur ◎ Stroke or TIA ◎ Heart Failure

◎ Atrial Fibrillation ◎ Pacemaker ◎ Irregular Heart Beat ◎ Peripheral Vascular Disease

◎ Reflux/ Heartburn ◎ Cancer ◎ COPD or Asthma ◎ Thyroid Problems

◎ HIV ◎ Kidney Problems ◎ Bleeding Problems ◎ Metabolic Syndrome

◎ Toxemia ◎ Polycystic Ovarian Syndrome ◎ Anxiety/ Depression

◎ _____ ◎ _____ ◎ _____ ◎ _____

PAST SURGICAL HISTORY

List any surgeries and dates that you have had:

◎ _____-_____ ◎ _____-_____ ◎ _____-_____ ◎ _____-_____

◎ _____-_____ ◎ _____-_____ ◎ _____-_____ ◎ _____-_____

SOCIAL HISTORY AND HABITS

Are any of the following applicable to you presently and/ or past (check/ bubble your response); also list conditions that are not below.

Marital Status: ◎ Single ◎ Divorced ◎ Widowed ◎ Domestic Partner

Occupation: ◎ _____ ◎ _____ ◎ Plan to return to work Post Partum

Do you drink alcohol? ◎ Yes, how often? __ Daily ___ Weekly __ Seldom ◎No

Do you exercise? ◎ Yes, what type do you enjoy? ___ Cardio ___ Weight Lifting ___ Other: _____ ◎No

FAMILY MEDICAL HISTORY

Please list below any of your immediate family who has ever had a heart attack, diabetes, angioplasty or bypass surgery, cardiac arrhythmia, sudden death, cancer, or other significant health problems. Immediate family member is deceased, please list age and cause of death:

◎ Mother: _____/ Age: ____ _____/ Age: ____ _____/ Age: ____ _____/ Age: ____

◎ Father: _____/ Age: ____ _____/ Age: ____ _____/ Age: ____ _____/ Age: ____

◎ Sibling 1: _____/ Age: ____ _____/ Age: ____ ◎ Sibling 2: _____/ Age: ____ _____/ Age: ____

◎ Other: _____/ Age: ____ _____/ Age: ____ ◎ Other: _____/ Age: ____ _____/ Age: ____

HISTORY OF ALLERGIES

Are any of the following applicable to you presently and/ or past (check/ bubble your response); also list conditions that are not below.

Are you allergic to: ◎ Aspirin ◎ IV Contrast Dye ◎ Latex ◎ Penicillin ◎ Shellfish ◎ No Known Drug Allergies

Other Medications: ◎ _____ ◎ _____ ◎ _____ ◎ _____

MEDICATION LIST

Do you have a copy of a medication list that has been provided at the time of your arrival? ◎ Yes ◎No

MEDICATON NAME	DOSE/ FREQUENCY	MEDICATON NAME	DOSE/ FREQUENCY
_____	____/ ____	_____	____/ ____
_____	____/ ____	_____	____/ ____

REVIEW OF SYSTEMS

Are any of the following applicable to you presently and/ or within the last 30 days (check/ bubble your response):

CARDIOVASCULAR	YES	NO
Chest Pain:	◎	◎
Heart Racing/ Irregular / Skipping beats:	◎	◎
Shortness of breath while exercising/walking:	◎	◎
Awakening from sleep short of breath:	◎	◎
CIRCULATORY		
Deep Vein Thrombosis:	◎	◎
Venous Dysfunction/ Insufficiency:	◎	◎
Veracious Veins:	◎	◎
CONSTITUTIONAL		
Fever:	◎	◎
Excessive/ Fatigue:	◎	◎
Weight Gain/ Loss:	◎	◎
EYES		
Glaucoma:	◎	◎
Visual Problems:	◎	◎
EARS, NOSE & THROAT		
Hearing Deficit:	◎	◎
Gout:	◎	◎
Nosebleed(s):	◎	◎
SKIN		
Bruising:	◎	◎
Rash:	◎	◎
NEUROLOGICAL		
Stroke:	◎	◎
Seizures:	◎	◎
One Sided weakness:	◎	◎

GASTROINTESTINAL	YES	NO
Abdominal Pain:	◎	◎
Blood in your Stool:	◎	◎
Nausea or vomiting:	◎	◎
Reflux/GERD or Heartburn:	◎	◎
Diarrhea or Constipation:	◎	◎
Liver Disease/ Cirrhosis:	◎	◎
Hepatitis:	◎	◎
Irritable Bowel Syndrome:	◎	◎
PSYCHAITRIC		
Depressed:	◎	◎
Anxiety:	◎	◎
GENITO-URINARY		
Blood in the urine:	◎	◎
Difficulty urinating:	◎	◎
MUSKULOSKELETAL		
Muscle Pain:	◎	◎
Ringing of the ears:	◎	◎
Arthritis or Joint Pain:	◎	◎
HEMATOLOGY		
Anemia:	◎	◎
Low Platelets:	◎	◎
RESPIRATORY		
Snoring:	◎	◎
Wheezing:	◎	◎
Cough:	◎	◎
Sleep Apnea (sleeping disorder)	◎	◎

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