## PRECONCEPTION SCREENING AND COUNSELING CHECKLIST

<table>
<thead>
<tr>
<th>NAME</th>
<th>BIRTHPLACE</th>
<th>AGE</th>
</tr>
</thead>
<tbody>
<tr>
<td>DATE: / / ARE YOU PLANNING TO GET PREGNANT IN THE NEXT SIX MONTHS? __ Y __ N</td>
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</tbody>
</table>

IF YOUR ANSWER TO A QUESTION IS YES, PUT A CHECK MARK ON THE LINE IN FRONT OF THE QUESTION. FILL IN OTHER INFORMATION THAT APPLIES TO YOU.

### DIET & EXERCISE
- What do you consider a healthy weight for you? __________
- Do you eat three meals a day? __________
- Do you follow a special diet (vegetarian, diabetic, other)? __________
- Which do you drink (coffee, tea, cola, milk, water, other soda/pop) __________
- Do you eat raw or undercooked food (meat, other)? __________
- Do you take folic acid? __________
- Do you take other vitamins daily (multivitamin, vitamin A, other)? __________
- Do you take dietary supplements (black cohosh, pennyroyal, other)? __________
- Do you have current/past problems with eating disorders? __________
- Do you exercise? Type/frequency: __________

Notes:

### LIFESTYLE
- Do you smoke cigarettes or use other tobacco products? __________
- How many cigarettes/packs a day? __________
- Are you exposed to second-hand smoke? __________
- Do you drink alcohol? __________
- What kind? __________
- How often? __________
- How much? __________
- Do you use recreational drugs (cannabis, heroin, ecstasy, meth, other)? List: __________
- Do you see a dentist regularly? __________
- What kind of work do you do? __________
- Do you work or live near possible hazards (chemicals, x-ray or other radiation, lead)? List: __________
- Do you use saunas or hot tubs? __________

Notes:

### MEDICATION/DRUGS
- Are you taking prescribed drugs (Accutane, valproic acid, blood thinners)? List them: __________
- Are you taking non-prescribed drugs? List them: __________
- Are you using birth control pills? __________
- Do you use any herbal remedies or alternative medicine? List: __________

Notes:

### MEDICAL/FAMILY HISTORY
- Do you have or have you ever had: __________
  - Epilepsy?
  - Diabetes?
  - Asthma?
  - High blood pressure?
  - Heart disease?
  - Anemia?
  - Kidney or bladder disorders?
  - Thyroid disease?
  - Chickenpox?
  - Hepatitis C?
  - Digestive problems?
  - Depression or other mental health problem?
  - Surgeries?
  - Lupus?
  - Scleroderma?
  - Other conditions?

Have you ever been vaccinated for: __________
  - Measles, mumps, rubella?
  - Hepatitis B?
  - Chickenpox?

Notes:

### WOMEN'S HEALTH
- Do you have any problems with your menstrual cycle? __________
- How many times have you been pregnant? __________
- What was/were the outcomes(s)? __________
- Did you have difficulty getting pregnant last time? __________
- Have you been treated for infertility? __________
- Have you had surgery on your uterus, cervix, ovaries or tubes? __________
- Did you mother take the hormone DES during pregnancy? __________
- Have you ever had HPV, genital warts or chlamydia? __________
- Have you ever been treated for a sexually transmitted infection (genital herpes, gonorrhea, syphilis, HIV/AIDS, other)? List: __________

Notes:

### HOME ENVIRONMENT
- Do you feel emotionally supported at home? __________
- Do you have help from relatives or friends if needed? __________
- Do you feel you have serious money/financial worries? __________
- Are you in a stable relationship? __________
- Do you feel safe at home? __________
- Does anyone threaten or physically hurt you? __________
- Do you have pets (cats, rodents, exotic animals)? List: __________
- Do you have any contact with soil, cat litter or sandboxes? __________
- Baby preparation (if planning pregnancy): __________
- Do you have a place for a baby to sleep? __________
- Do you need any baby items? __________

Notes:

### GENETICS
- Does your family have a history of __________ or your partner’s family __________
  - Hemophilia?
  - Other bleeding disorders?
  - Tay-Sachs disease?
  - Blood diseases (sickle cell, thalassemia, other)?
  - Muscular dystrophy?
  - Down syndrome/Mental retardation?
  - Cystic fibrosis?
  - Birth defects (spine/heart/kidney)?

Your ethnic background is: __________
Your partner’s ethnic background is: __________

Notes:

### OTHER
- IS THERE ANYTHING ELSE YOU'D LIKE ME TO KNOW?

ARE THERE ANY QUESTIONS YOU'D LIKE TO ASK ME?