Reproductive Health Questions

Your Medical History. Please list any medical conditions that you have, such as diabetes, high blood pressure, seizures, thyroid disease, depression, anemia, etc.
__________________________________________________________________
__________________________________________________________________
__________________________________________________________________

Your Medications. Please list any prescription or over-the-counter medications, vitamins, herbs, or supplements that you take on a regular basis.
__________________________________________________________________
__________________________________________________________________
__________________________________________________________________

Your Pregnancy History.
How many pregnancies have you had?  ____ □ None (if ‘none’, skip to ‘Your Family Medical History section).

How many babies have you delivered early (before 37 weeks)?  ____ □ None
How many babies have you delivered weighing less than 5 lbs 8 oz?  ____ □ None
How many miscarriages have you had?  ____ □ None
How many abortions have you had?  ____ □ None
During any of your pregnancies, did you have any problems like:
  High blood pressure □ Yes □ No
  Diabetes □ Yes □ No
  Vaginal bleeding □ Yes □ No
  Premature labor □ Yes □ No

Your Family Medical History. Please put an ‘x’ in the box for any conditions that run in your family.
□ Birth defects (like heart problems, open spine, cleft palate, or other problems)
□ Miscarriages, stillbirths, or children who die soon after birth
□ Hearing loss or deafness
□ Vision loss or blindness
□ Mental retardation, learning disabilities, or Fragile X syndrome
□ Cystic fibrosis
□ Hemophilia
□ Sickle cell trait or disease
□ Muscular dystrophy
□ Phenylketonuria
□ Other ____________________________________________________________________
Your Job and Hobbies.
What type of work do you do? __________________________________________
Do you work with pesticides, dry cleaning fluids, paint strippers, oven cleaners, ceramics, solder, or welding at home or at work? □ Yes □ No
Do you work with radiation or x-rays? □ Yes □ No
Do you change cat litter boxes? □ Yes □ No

Your Diet and Nutrition.
Do you take a vitamin containing folic acid each day? □ Yes □ No □ Don’t know
Do you eat cereal fortified with folic acid each day? □ Yes □ No □ Don’t know
Name of cereal: ______________________
Do you eat raw or very rare meats or fish? □ Yes □ No
Do you eat unpasteurized dairy products? □ Yes □ No
Do you eat soft cheeses like feta, blue, brie, or queso fresco? □ Yes □ No

Your Sexual Practices.
Have you ever had a sexually-transmitted infection? □ Yes □ No
Have you had sex with more than one partner or has your partner had sex with more than one partner? □ Yes □ No
Some women and some men use sex to get things they need.
Have you ever had to do this? □ Yes □ No
As far as you know, have you ever had sex with someone who
  ▪ had HIV or AIDS or a sexually transmitted infection? □ Yes □ No
  ▪ was a man who had sex with men? □ Yes □ No
  ▪ used IV drugs or put drugs into their veins? □ Yes □ No
  ▪ was a prostitute? □ Yes □ No
  ▪ was a free bleeder or hemophiliac? □ Yes □ No
Has the use of alcohol or any other drug ever caused you to do things sexually that you normally would not do? □ Yes □ No
Have you ever had a job that exposed you to blood or other body fluids? □ Yes □ No
Do you prefer to have sex with men, women, or both? □ Men □ Women □ Both