Becoming A Parent

Preconception Checklist

NOTE TO FUTURE PARENTS:

If you are healthy before you are pregnant, then you are more likely to have a healthy baby when you do get pregnant. If you are already pregnant, it is still important to get as healthy as possible right now! By answering the questions in this checklist, your health care provider can help you get in the best health for you and your baby!

A "health care provider" is a doctor, nurse, social worker, dietitian, or health educator. These people take care of women before and during pregnancy. They may also take care of the child after birth.

This checklist helps you prepare for a healthy pregnancy and birth. You and your partner should each complete the checklist. It may be possible to lower risks you find by taking action now. The best time to visit your health care provider is before you are pregnant. Some things can affect the baby very early in pregnancy.

Some of the questions in this checklist are very personal. Please try to be as honest as you can with your answers. The information is important for you and your baby's health.

- ❏ Read and answer each of the questions.
- ❏ Put a check mark in the correct block for each question.
- ❏ Highlight anything you would like to talk about with your health care provider.
- ❏ Write down questions you have for your health care provider in the spaces called QUESTIONS AND NOTES.
- ❏ After you and your partner have finished the checklist, take it with you when you visit your health care provider.

NOTE TO HEALTH CARE PROVIDERS:

Please review this checklist with the individuals you serve. It should assist you to identify potential risks related to pregnancy, and to provide counseling, treatment, or referral appropriate to your clients' risks and pregnancy plans. For more information, please also see the "Health Care Provider's Reference" that accompanies the checklist. It may be reviewed online at www.perinatalweb.org.

If you have any questions or comments, please contact:

Wisconsin Association for Perinatal Care
McConnell Hall
1010 Mound Street
Madison, Wisconsin 53715
608-267-6060
Web site: www.perinatalweb.org

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FAMILY MEDICAL HISTORY

Notes: To complete this part, it may be helpful to talk with people in your family. In this case, "family" means any blood relative (living or dead), such as your mother, father, grandparents, brothers, sisters, aunts, and uncles. Include all such relatives, whether living or not.

(■ Shaded blocks mean the question does not apply. Just leave it blank. Any "Yes" or "Uncertain" checks in the blocks suggest the need for discussion with your health care provider.)

	WOMAN			MAN		
	YES	NO	UNCERTAIN	YES	NO	UNCERTAIN
Has anyone in your family:						
Had birth defects (such as heart problems, open spine, cleft palate or lip, or other problems)?	☐	☐	☐	☐	☐	☐
Had inherited diseases, such as:						
Cystic fibrosis?	☐	☐	☐	☐	☐	☐
Hemophilia?	☐	☐	☐	☐	☐	☐
Sickle cell disease or trait?	☐	☐	☐	☐	☐	☐
Tay-Sachs disease?	☐	☐	☐	☐	☐	☐
Canavan disease?	☐	☐	☐	☐	☐	☐
Muscular dystrophy?	☐	☐	☐	☐	☐	☐
Huntington chorea?	☐	☐	☐	☐	☐	☐
Phenylketonuria?	☐	☐	☐	☐	☐	☐
Had diabetes?	☐	☐	☐	☐	☐	☐
Attempted or committed suicide?	☐	☐	☐	☐	☐	☐
Had a problem with alcohol or other drugs?	☐	☐	☐	☐	☐	☐
Had depression or bipolar illness?	☐	☐	☐	☐	☐	☐
Had anxiety disorder, panic disorder, obsessive-compulsive disorder, or post-traumatic stress disorder?	☐	☐	☐	☐	☐	☐
Been hospitalized for mental health reasons?	☐	☐	☐	☐	☐	☐
Had hearing loss/ear abnormalities?	☐	☐	☐	☐	☐	☐
Had blindness/severe vision problems?	☐	☐	☐	☐	☐	☐
Had mental retardation, learning disabilities, or Fragile X syndrome?	☐	☐	☐	☐	☐	☐
Had miscarriages, stillbirths, or children who died soon after birth?	☐	☐	☐	☐	☐	☐
Had difficulty getting pregnant (trying for more than 1 year)?	☐	☐	☐	☐	☐	☐

QUESTIONS AND NOTES:

YOUR MEDICAL HISTORY

(■ Shaded blocks mean the question does not apply. Just leave it blank. Any "Yes" or "Uncertain" checks in the blocks suggest the need for discussion with your health care provider.)

	WOMAN			MAN		
	YES	NO	UNCERTAIN	YES	NO	UNCERTAIN
Are you 16 years old or younger?	☐	☐	☐	☐	☐	☐
Are you 35 years old or older?	☐	☐	☐	☐	☐	☐
Do you have, or have you ever had:						
Anemia (e.g., "low iron blood count")?	☐	☐	☐	☐	☐	☐
High blood pressure?	☐	☐	☐	☐	☐	☐
Heart disease?	☐	☐	☐	☐	☐	☐
Problems identified at your birth?	☐	☐	☐	☐	☐	☐
Thyroid disease?	☐	☐	☐	☐	☐	☐
Epilepsy or seizures?	☐	☐	☐	☐	☐	☐
Depression?	☐	☐	☐	☐	☐	☐
Bipolar illness?	☐	☐	☐	☐	☐	☐
Anxiety, panic, obsessive-compulsive disorder, or post-traumatic stress disorder?	☐	☐	☐	☐	☐	☐
Problems with alcohol or other drugs?	☐	☐	☐	☐	☐	☐
Insulin resistance, pre-diabetes, borderline diabetes, or high blood sugar?	☐	☐	☐	☐	☐	☐
Diabetes requiring insulin or other drugs?	☐	☐	☐	☐	☐	☐
Blood clots in your legs or lungs?	☐	☐	☐	☐	☐	☐
Bladder or kidney infections or problems?	☐	☐	☐	☐	☐	☐
Genital herpes, gonorrhea, syphilis, chlamydia, or genital warts?	☐	☐	☐	☐	☐	☐
An abnormal Pap smear?	☐	☐	☐	☐	☐	☐
Cancer?	☐	☐	☐	☐	☐	☐
If yes, age at which you had cancer.	AGE _____			AGE _____		
What type of cancer?						
Any other medical problems (such as lupus, asthma, etc.)?	☐	☐	☐	☐	☐	☐
Do you have HIV infection/AIDS?	☐	☐	☐	☐	☐	☐
Has it been more than 6 months since you had a dental check up?	☐	☐	☐	☐	☐	☐

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YOUR MEDICAL HISTORY

(■ Shaded blocks mean the question does not apply. Just leave it blank. Any "Yes" or "Uncertain" checks in the blocks suggest the need for discussion with your health care provider.)

	WOMAN			MAN		
	YES	NO	UNCERTAIN	YES	NO	UNCERTAIN
Do you have any mouth or dental problems?	☐	☐	☐	☐	☐	☐
Have you been exposed to tuberculosis?	☐	☐	☐	☐	☐	☐
Are you frequently around young children?	☐	☐	☐	☐	☐	☐
Have you experienced physical, sexual, or emotional abuse; incest; or rape?	☐	☐	☐	☐	☐	☐
Have you ever been hospitalized for mental health reasons?	☐	☐	☐	☐	☐	☐
Have you ever attempted suicide?	☐	☐	☐	☐	☐	☐
Do you take a multi-vitamin with 400 micrograms of folic acid every day?	☐	☐	☐	■	■	■
Are you taking any prescription drugs?	☐	☐	☐	☐	☐	☐
Do you use over-the-counter (non-prescription) drugs?	☐	☐	☐	☐	☐	☐
Do you take any vitamins, minerals, or herbal or food supplements?	☐	☐	☐	☐	☐	☐
Have you had or been immunized against:						
*German measles (rubella)?	☐	☐	☐	☐	☐	☐
*Chicken pox (varicella zoster)?	☐	☐	☐	☐	☐	☐
*Hepatitis B?	☐	☐	☐	☐	☐	☐
*Mumps?	☐	☐	☐	☐	☐	☐

*A "No" or "Uncertain" check in this block suggests the need for discussion with your health care provider.

Please list all medications, drugs, vitamins, and pills for the items checked above. Please take these items with you to your appointment.

QUESTIONS AND NOTES:

REPRODUCTIVE HEALTH

(■ Shaded blocks mean the question does not apply. Just leave it blank. Any "Yes" or "Uncertain" checks in the blocks suggest the need for discussion with your health care provider.)

	WOMAN			MAN		
	YES	NO	UNCERTAIN	YES	NO	UNCERTAIN
Do you know of any problems with your reproductive organs?	☐	☐	☐	☐	☐	☐
Did you ever have epididymitis or an infection in your reproductive organs?	■	■	■	☐	☐	☐
Have you ever had surgery on your penis or testicles?	■	■	■	☐	☐	☐
Have you had any miscarriages?	☐	☐	☐	☐	☐	☐
Have any of your children been stillborn or died soon after birth?	☐	☐	☐	☐	☐	☐
Have any of your children weighed less than 5 1/2 pounds at birth?	☐	☐	☐	☐	☐	☐
Have any of your children weighed more than 9 pounds at birth?	☐	☐	☐	☐	☐	☐
Did any of your children need care in an intensive care nursery?	☐	☐	☐	☐	☐	☐
Did any of your children have to stay in the hospital after you or your partner went home?	☐	☐	☐	☐	☐	☐
Do you have any questions or concerns about being able to become pregnant, or to father a child?	☐	☐	☐	☐	☐	☐
Are you using anything to prevent pregnancy?	☐	☐	☐	☐	☐	☐

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QUESTIONS AND NOTES:

REPRODUCTIVE HEALTH

(■ Shaded blocks mean the question does not apply. Just leave it blank. Any "Yes" or "Uncertain" checks in the blocks suggest the need for discussion with your health care provider.)

	WOMAN			MAN		
	YES	NO	UNCERTAIN	YES	NO	UNCERTAIN
Do you have endometriosis?	☐	☐	☐	■	■	■
Have you ever had surgery on your ovaries, uterus, cervix, fallopian tubes, or vagina?	☐	☐	☐	■	■	■
Did you ever have Pelvic Inflammatory Disease (PID) or an infection in your tubes or pelvis?	☐	☐	☐	■	■	■
In any past pregnancies, did you have any problems (such as high blood pressure, diabetes, vaginal bleeding, premature labor, signs that the baby was in trouble, or difficult deliveries)?	☐	☐	☐	■	■	■
Do you have a menstrual period every month?	☐	☐	☐	■	■	■
Have you ever had abdominal surgery (for example, removal of the appendix)?	☐	☐	☐	■	■	■
Have you had a child in the last year?	☐	☐	☐	■	■	■
Have you been pregnant 5 or more times?	☐	☐	☐	■	■	■
Have you had any abortions?	☐	☐	☐	■	■	■
Have you delivered a baby early?	☐	☐	☐	■	■	■

QUESTIONS AND NOTES:

(■ Shaded blocks mean the question does not apply. Just leave it blank. Any "Yes" or "Uncertain" checks in the blocks suggest the need for discussion with your health care provider.)

	WOMAN			MAN		
	YES	NO	UNCERTAIN	YES	NO	UNCERTAIN
Are you happy with your weight?	☐	☐	☐	☐	☐	☐
Do you have or have you ever had an eating disorder (for example, anorexia or bulimia)?	☐	☐	☐	■	■	■
Do you ever eat laundry starch, clay, dirt, or other things that are not foods?	☐	☐	☐	■	■	■
Are you on a special diet (either to lose or gain weight, vegetarian, etc.)?	☐	☐	☐	☐	☐	☐
Do you skip meals?	☐	☐	☐	☐	☐	☐
Do you ever eat raw or very rare meats or fish?	☐	☐	☐	☐	☐	☐
Do you eat fish more than once a week?	☐	☐	☐	☐	☐	☐
Do you eat unpasteurized dairy products?	☐	☐	☐	☐	☐	☐
Do you eat soft cheeses such as feta, blue, brie, or Mexican-style cheeses?	☐	☐	☐	☐	☐	☐
Are there foods that don't agree with you or that you are allergic to?	☐	☐	☐	☐	☐	☐
*Do you eat a variety of foods (breads and cereals, fruits and vegetables, dairy products and meats)?	☐	☐	☐	☐	☐	☐

*A "No" or "Uncertain" check in this block suggests the need for discussion with your health care provider.

QUESTIONS AND NOTES:

HOME, WORK, OR SOCIAL HAZARDS

(■ Shaded blocks mean the question does not apply. Just leave it blank. Any "Yes" or "Uncertain" checks in the blocks suggest the need for discussion with your health care provider.)

What is your occupation? (Write in.)

	WOMAN			MAN		
	YES	NO	UNCERTAIN	YES	NO	UNCERTAIN
Do you work with metals or chemicals at work or at home (paint strippers, oven cleaners, ceramics or solder, pesticides, etc.)?	☐	☐	☐	☐	☐	☐
Are you exposed to high levels of heat at work or home or use hot tubs, whirlpool baths, or saunas?	☐	☐	☐	☐	☐	☐
Do you have a job that is physically hard work (heavy lifting, prolonged standing)?	☐	☐	☐	■	■	■
Do you work with radiation or will you be exposed to x-rays?	☐	☐	☐	☐	☐	☐
Are you exposed to lead at home or work (through paint removal or remodeling, battery making, soldering, welding, radiator repair, or working at a firing range)?	☐	☐	☐	☐	☐	☐
Do you have contact with a cat litter box?	☐	☐	☐	■	■	■
Has your drinking water been tested for lead, nitrates, or other contaminants?	☐	☐	☐	☐	☐	☐
If your drinking water was tested, were any contaminants found?	☐	☐	☐	☐	☐	☐
Are there family, friends, or work problems complicating things?	☐	☐	☐	☐	☐	☐

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QUESTIONS AND NOTES:

HOME, WORK, OR SOCIAL HAZARDS

(■ Shaded blocks mean the question does not apply. Just leave it blank. Any "Yes" or "Uncertain" checks in the blocks suggest the need for discussion with your health care provider.)

	WOMAN			MAN		
	YES	NO	UNCERTAIN	YES	NO	UNCERTAIN
Do you smoke cigarettes?	☐	☐	☐	☐	☐	☐
If yes, how many a day?	#:_____			#: _____		
Do you breathe second-hand smoke?	☐	☐	☐	☐	☐	☐
Do you drink beer, wine, or hard liquor?	☐	☐	☐	☐	☐	☐
How many drinks does it take to make you feel high?	#:_____			#: _____		
Have people annoyed you by criticizing your drinking?	☐	☐	☐	☐	☐	☐
Have you felt you ought to cut down on your drinking?	☐	☐	☐	☐	☐	☐
Have you ever had a drink first thing in the morning to steady your nerves or get rid of a hangover?	☐	☐	☐	☐	☐	☐
Do you use any recreational or street drugs (such as marijuana, cocaine, crack, etc.)?	☐	☐	☐	☐	☐	☐

QUESTIONS AND NOTES:

PARENTING CONSIDERATIONS

(■ Shaded blocks mean the question does not apply. Just leave it blank. Any "Yes" or "Uncertain" checks in the blocks suggest the need for discussion with your health care provider.)

	WOMAN			MAN		
	YES	NO	UNCERTAIN	YES	NO	UNCERTAIN
Do you have thoughts about:						
What is a "perfect" child?	☐	☐	☐	☐	☐	☐
What is a "perfect" parent?	☐	☐	☐	☐	☐	☐
Is pregnancy likely to cause problems in the following:						
Family finances?	☐	☐	☐	☐	☐	☐
Living space?	☐	☐	☐	☐	☐	☐
Your career plans?	☐	☐	☐	☐	☐	☐
Child care?	☐	☐	☐	☐	☐	☐
Your social life?	☐	☐	☐	☐	☐	☐
Your independence and privacy?	☐	☐	☐	☐	☐	☐
Is there anything that makes you wonder if you are capable of being a parent?	☐	☐	☐	☐	☐	☐

QUESTIONS AND NOTES:

ADDITIONAL QUESTIONS OR CONCERNS

Write down any other questions or concerns you have about your pregnancy plans. Talk to your health care provider about them.

Date of preconception visit _____Time_____

Name of health care provider _____

Address _____

Phone _____