Becoming A Parent

Preconception Checklist

NOTE TO PROSPECTIVE PARENTS:

If you are in good health before you become pregnant, you increase the chances of having a healthy baby. If you are already pregnant, your answers to the items in this checklist will give your health care provider ways to assist you in improving both your health and your future child's health.

This checklist was created to help you to:

- Plan and Prepare for Becoming a Parent
- Prepare for a Healthy Pregnancy and Birth
- Begin Prenatal Care Early

You and your partner should each fill in the checklist. If you have risks that could be a problem for you or your future child's health, it may be possible to lower those risks by taking action *before conception.*

Carefully read and answer each of the questions. Mark all of the items that apply by putting a check mark in the correct box. Make note of anything you would like to talk about with your health care provider. Write your notes in the *QUESTIONS AND NOTES* space at the end of each part. After you and your partner have finished the checklist, take it with you when you visit your health care provider.

The term "Health Care Provider" refers to doctors, nurses, social workers, dietitians and health educators who give care related to pregnancy. This includes health care from a few months before a woman gets pregnant, through the baby's first year of life.

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

NOTE TO HEALTH CARE PROVIDERS:

We encourage you to 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.

If you have any questions or comments, please contact:

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FAMILY MEDICAL HISTORY

Note: To complete this part, it may be helpful to talk with members of your family. In the following questions, "family" means any blood relative (living or dead), including mother, father, grandparents, brothers, sisters, aunts and uncles.

	WOMAN			MAN		
	YES	NO	UNCERTAIN	YES	NO	UNCERTAIN
HAS ANYONE IN YOUR FAMILY HAD:						
Birth defects (e.g., heart defects, open spine, cleft palate or lip, or other problems)?	☐	☐	☐	☐	☐	☐
Mental retardation?	☐	☐	☐	☐	☐	☐
Inherited diseases (e.g., cystic fibrosis, hemophilia, sickle cell disease or Tay Sachs disease)?	☐	☐	☐	☐	☐	☐
Any other hereditary conditions?	☐	☐	☐	☐	☐	☐
High blood pressure?	☐	☐	☐	☐	☐	☐
Diabetes?	☐	☐	☐	☐	☐	☐
Thyroid disease?	☐	☐	☐	☐	☐	☐
Miscarriages, stillbirths, or children who died soon after birth?	☐	☐	☐	☐	☐	☐
Difficulty getting pregnant?	☐	☐	☐	☐	☐	☐
Premature babies or babies weighing less than 5 1/2 pounds at birth?	☐	☐	☐	☐	☐	☐

QUESTIONS AND NOTES:

YOUR MEDICAL HISTORY

	WOMAN			MAN		
	YES	NO	UNCERTAIN	YES	NO	UNCERTAIN
Are you 16 years old or younger?	☐	☐	☐	☐	☐	☐
Are you 35 years old or older?	☐	☐	☐	☐	☐	☐
*Have you had rubella (German measles) or been immunized against it?	☐	☐	☐	■	■	■
*Have you had mumps?	■	■	■	☐	☐	☐
Do you have, or have you ever had:						
Anemia (e.g., "low blood")?	☐	☐	☐	☐	☐	☐
High blood pressure?	☐	☐	☐	☐	☐	☐
Heart disease?	☐	☐	☐	☐	☐	☐
Cancer?	☐	☐	☐	☐	☐	☐
If yes, age at which you had cancer.	AGE: ______			AGE: ______		
Diabetes?	☐	☐	☐	☐	☐	☐
Epilepsy or seizures?	☐	☐	☐	☐	☐	☐
Phenylketonuria (PKU)?	☐	☐	☐	☐	☐	☐
Urinary tract infections or kidney problems?	☐	☐	☐	☐	☐	☐
Genital herpes, gonorrhea, syphilis, chlamydia or genital warts?	☐	☐	☐	☐	☐	☐
Exposure to HIV (the AIDS virus)?	☐	☐	☐	☐	☐	☐
An abnormal Pap smear?	☐	☐	☐	■	■	■
Any other medical problems (e.g., lupus, blood clots, asthma, etc.)?	☐	☐	☐	☐	☐	☐
Have you had a dental check-up in the last six months?	☐	☐	☐	☐	☐	☐

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

(■ Shaded blocks mean the question does not apply. Just leave blank.)

QUESTIONS AND NOTES:

REPRODUCTIVE HISTORY

	WOMAN			MAN		
	YES	NO	UNCERTAIN	YES	NO	UNCERTAIN
Do you know of any problems with your reproductive organs?	☐	☐	☐	☐	☐	☐
Have you ever had surgery on your ovaries, uterus, cervix, fallopian tubes or vagina?	☐	☐	☐	■	■	■
Have you ever had surgery on your penis or testicles?	■	■	■	☐	☐	☐
Have you ever had any abdominal surgery (e.g., appendix or bowel)?	☐	☐	☐	■	■	■
Have you had a child in the last year?	☐	☐	☐	☐	☐	☐
Have you been pregnant 5 or more times?	☐	☐	☐	■	■	■
Have you had any miscarriages or abortions?	☐	☐	☐	■	■	■
Have you had any stillborn children, or children die 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 went home?	☐	☐	☐	■	■	■
In any past pregnancies, did you have problems (e.g., high blood pressure, vaginal bleeding, premature labor, signs that the baby was in trouble or difficult deliveries)?	☐	☐	☐	■	■	■
Did you ever have Pelvic Inflammatory Disease (PID) or have an infection in your tubes or pelvis?	☐	☐	☐	■	■	■
Do you have irregular menstrual periods?	☐	☐	☐	■	■	■
Do you have any questions or concerns about being able to become pregnant, or to father a child?	☐	☐	☐	☐	☐	☐

(■ Shaded blocks mean the question does not apply. Just leave blank.)

QUESTIONS AND NOTES:

DRUG HISTORY

	WOMAN			MAN		
	YES	NO	UNCERTAIN	YES	NO	UNCERTAIN
Are you taking any prescription drugs?	☐	☐	☐	☐	☐	☐
Are you using birth control pills or other hormonal contraceptives, i.e., Norplant, Depo-Provera injections?	☐	☐	☐	■	■	■
Do you use over-the-counter (non-prescription) drugs?	☐	☐	☐	☐	☐	☐
Do you take any vitamins, minerals or food supplements?	☐	☐	☐	■	■	■
*If yes: Do you take a multi-vitamin containing 0.4mg of folic acid every day?	☐	☐	☐	■	■	■
Do you use any recreational or street drugs (e.g., marijuana, cocaine, crack, etc.)?	☐	☐	☐	☐	☐	☐
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?	☐	☐	☐	☐	☐	☐

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

(■ Shaded blocks mean the question does not apply. Just leave blank.)

QUESTIONS AND NOTES:

Please list all medications, drugs, vitamins and pills for the items checked above.

(continued on back)

NUTRITION

	WOMAN			MAN		
	YES	NO	UNCERTAIN	YES	NO	UNCERTAIN
Do you think you are overweight or underweight?	☐	☐	☐	☐	☐	☐
*Do you know your current weight?	☐	☐	☐	☐	☐	☐
Are you on a special diet (e.g., weight loss or gain, vegetarian, etc.)?	☐	☐	☐	☐	☐	☐
Do you skip meals?	☐	☐	☐	☐	☐	☐
*Do you eat a variety of foods (e.g., breads and cereals, fruits and vegetables, dairy products and meats)?	☐	☐	☐	☐	☐	☐
Do you ever eat laundry starch, clay, dirt or other "non-foods"?	☐	☐	☐	■	■	■
Do you ever eat raw or very rare meats or fish?	☐	☐	☐	☐	☐	☐
Do you eat fish caught in Wisconsin waters?	☐	☐	☐	☐	☐	☐
Are there foods that don't agree with you?	☐	☐	☐	☐	☐	☐
Are there foods you strongly dislike?	☐	☐	☐	☐	☐	☐

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

(■ Shaded blocks mean the question does not apply. Just leave blank.)

QUESTIONS AND NOTES:

HOME OR WORKPLACE HAZARDS

	WOMAN			MAN		
	YES	NO	UNCERTAIN	YES	NO	UNCERTAIN
Do you work with metals or chemicals?	☐	☐	☐	☐	☐	☐
Are you exposed to high levels of heat or noise on the job?	☐	☐	☐	☐	☐	☐
Do you have a job that is physically hard work?	☐	☐	☐	☐	☐	☐
Do you work with radiation or will you be exposed to x-rays?	☐	☐	☐	☐	☐	☐
Do you use chemicals at home or in your hobbies (e.g., paint strippers, oven cleaners, pesticides, ceramics or solder)?	☐	☐	☐	☐	☐	☐
Are you exposed to lead dust at home through paint removal or remodeling?	☐	☐	☐	☐	☐	☐
Do you have contact with a cat litter box?	☐	☐	☐	■	■	■
Has your drinking water been tested for lead, nitrates or other contaminants?	☐	☐	☐	☐	☐	☐

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

(■ Shaded blocks mean the question does not apply. Just leave blank.)

QUESTIONS AND NOTES:

PERSONAL AND SOCIAL HISTORY

	WOMAN			MAN		
	YES	NO	UNCERTAIN	YES	NO	UNCERTAIN
Have you, your parents, grandparents, or brothers and sisters had a history of:						
Depression?	☐	☐	☐	☐	☐	☐
Other emotional problems?	☐	☐	☐	☐	☐	☐
Being hospitalized for psychiatric reasons?	☐	☐	☐	☐	☐	☐
Has anyone in your family committed suicide?	☐	☐	☐	☐	☐	☐
Has anyone in your family had a problem with alcohol or other drugs?	☐	☐	☐	☐	☐	☐
Have you or other family members experienced violence (e.g., child abuse, spouse abuse, incest or rape)?	☐	☐	☐	☐	☐	☐
Are you experiencing a lot of stress in any area of your life now?	☐	☐	☐	☐	☐	☐
Is there anything that makes you wonder if you are capable of parenting?	☐	☐	☐	☐	☐	☐

QUESTIONS AND NOTES:

PARENTING CONSIDERATIONS

	WOMAN			MAN		
	YES	NO	UNCERTAIN	YES	NO	UNCERTAIN
Do you have thoughts about:						
What is a "perfect" child?	☐	☐	☐	☐	☐	☐
What is a "perfect" parent?	☐	☐	☐	☐	☐	☐
Have you considered the possible changes pregnancy and parenthood will have on:						
*Family finances?	☐	☐	☐	☐	☐	☐
*Living space?	☐	☐	☐	☐	☐	☐
*Career plans?	☐	☐	☐	☐	☐	☐
*Child care?	☐	☐	☐	☐	☐	☐
*Social Life?	☐	☐	☐	☐	☐	☐
*Independence and privacy?	☐	☐	☐	☐	☐	☐

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

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 preconceptional visit ______________________ Time ______________________

Name of health care provider ____

Address ____

Phone ____

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