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# 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:



Wisconsin Association for Perinatal Care  
McConnell Hall  
1010 Mound Street  
Madison, Wisconsin 53715  
608-267-6060

## 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
<b>HAS ANYONE IN YOUR FAMILY HAD:</b>						
Birth defects (e.g., heart defects, open spine, cleft palate or lip, or other problems)?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Mental retardation?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Inherited diseases (e.g., cystic fibrosis, hemophilia, sickle cell disease or Tay Sachs disease)?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Any other hereditary conditions?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
High blood pressure?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Thyroid disease?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Miscarriages, stillbirths, or children who died soon after birth?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Difficulty getting pregnant?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Premature babies or babies weighing less than 5 1/2 pounds at birth?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

### QUESTIONS AND NOTES:

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## REPRODUCTIVE HISTORY

	WOMAN			MAN		
	YES	NO	UNCERTAIN	YES	NO	UNCERTAIN
Do you know of any problems with your reproductive organs?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Have you ever had surgery on your ovaries, uterus, cervix, fallopian tubes or vagina?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
Have you ever had surgery on your penis or testicles?	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Have you ever had any abdominal surgery (e.g., appendix or bowel)?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
Have you had a child in the last year?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Have you been pregnant 5 or more times?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
Have you had any miscarriages or abortions?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
Have you had any stillborn children, or children die soon after birth?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Have any of your children weighed less than 5 1/2 pounds at birth?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Have any of your children weighed more than 9 pounds at birth?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Did any of your children need care in an intensive care nursery?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Did any of your children have to stay in the hospital after you went home?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
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)?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
Did you ever have Pelvic Inflammatory Disease (PID) or have an infection in your tubes or pelvis?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
Do you have irregular menstrual periods?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
Do you have any questions or concerns about being able to become pregnant, or to father a child?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

(■ 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?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Are you using birth control pills or other hormonal contraceptives, i.e., Norplant, Depo-Provera injections?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
Do you use over-the-counter (non-prescription) drugs?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Do you take any vitamins, minerals or food supplements?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
*If yes: Do you take a multi-vitamin containing 0.4mg of folic acid every day?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
Do you use any recreational or street drugs (e.g., marijuana, cocaine, crack, etc.)?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Do you smoke cigarettes?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
If yes: How many a day?	#: _____			#: _____		
Do you breathe second-hand smoke?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Do you drink beer, wine or hard liquor?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
How many drinks does it take to make you feel high?	#: _____			#: _____		
Have people annoyed you by criticizing your drinking?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Have you felt you ought to cut down on your drinking?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Have you ever had a drink first thing in the morning to steady your nerves or get rid of a hangover?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

\*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.

## NUTRITION

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

\*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?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Are you exposed to high levels of heat or noise on the job?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Do you have a job that is physically hard work?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Do you work with radiation or will you be exposed to x-rays?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Do you use chemicals at home or in your hobbies (e.g., paint strippers, oven cleaners, pesticides, ceramics or solder)?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Are you exposed to lead dust at home through paint removal or remodeling?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Do you have contact with a cat litter box?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
Has your drinking water been tested for lead, nitrates or other contaminants?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

\*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?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other emotional problems?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Being hospitalized for psychiatric reasons?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Has anyone in your family committed suicide?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Has anyone in your family had a problem with alcohol or other drugs?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Have you or other family members experienced violence (e.g., child abuse, spouse abuse, incest or rape)?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Are you experiencing a lot of stress in any area of your life now?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Is there anything that makes you wonder if you are capable of parenting?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

### QUESTIONS AND NOTES:

## PARENTING CONSIDERATIONS

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

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

### QUESTIONS AND NOTES:

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## 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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