

Risk factors for pregnancy complications



How clinicians think about pregnancy risk

Risk assessment in pregnancy is usually cumulative rather than binary. In practice, clinicians weigh multiple small and large factors together: the presence of chronic disease, the history of previous births or losses, maternal age, body weight, medication exposures, and current pregnancy findings. A person may have one notable risk factor and still experience an uncomplicated pregnancy, while another person may have several moderate risks that add up to a more complex picture.

It is also important to remember that risk is dynamic. Some issues are known before conception, such as chronic hypertension or diabetes. Others emerge later, such as gestational hypertension, preeclampsia, fetal growth concerns, or infection. That is why prenatal care is not just a set of routine visits; it is a process of ongoing reassessment. When the risk profile changes, monitoring and counseling usually change too.

Preexisting medical conditions that raise risk

Preexisting maternal conditions are among the most established risk factors for pregnancy complications. Chronic hypertension, pregestational diabetes, thyroid

disease, obesity, and polycystic ovary syndrome are all commonly associated with higher rates of obstetric problems. The mechanism is not identical for each disorder, but the general principle is similar: pregnancy places extra demands on the cardiovascular, metabolic, and endocrine systems, and disease that is already active may be less able to adapt.

For example, uncontrolled blood pressure can increase the likelihood of placental problems and hypertensive complications, while diabetes can affect fetal growth and maternal organ function. Thyroid disorders may influence conception, pregnancy maintenance, and fetal neurodevelopment if not monitored appropriately. PCOS often overlaps with insulin resistance, weight-related metabolic stress, and irregular ovulation, which can complicate early pregnancy care. In these settings, preconception counseling for chronic disease can be very helpful because it gives time to review medications, optimize laboratory values, and aim for stable disease control before conception.

Other long-term illnesses can also matter, especially if they affect the kidneys, heart, lungs, blood vessels, or immune system. The important point is not to label every chronic condition as dangerous, but to recognize that baseline health before pregnancy often shapes the level of surveillance needed later.

Pregnancy history, age, and multiple gestation

What happened in earlier pregnancies can be one of the strongest clues about future risk. A history of preeclampsia, preterm labor before 37 weeks, fetal growth restriction, stillbirth, placental abruption, or recurrent pregnancy loss increases the chance that similar issues could recur. Prior cesarean delivery or uterine surgery may also affect current management, depending on the individual circumstances. For this reason, clinicians often spend a great deal of time reviewing obstetric history in detail rather than treating all pregnancies as interchangeable.

Maternal age matters as well, but it should be interpreted carefully. Pregnancy under age 20 and over age 35 is associated with higher complication rates in population studies, yet age itself is only one part of the picture. Biological maturity, chronic illness burden, social support, and access to care all contribute. Younger patients may face nutritional, social, or developmental

challenges; older patients may be more likely to have hypertension, diabetes, or fertility treatment exposure.

Multiple gestation, such as twins or higher-order multiples, also raises risk because it increases placental demand, the chance of preterm birth, and the likelihood of growth discordance. Even when the pregnancy is otherwise healthy, multiples generally justify more frequent follow-up. In many cases, a history of preterm labor before 37 weeks or a current multiple pregnancy is a reason for more careful counseling about warning signs and timing of visits.

Lifestyle factors and exposures that can be modified

Some of the most important pregnancy risk factors are modifiable, which is encouraging because it means risk can sometimes be reduced rather than simply accepted. Smoking, alcohol use, and nonmedical substance use are all associated with worse pregnancy outcomes. Tobacco exposure is linked to placental and fetal growth problems, while alcohol can affect fetal development. Substance use may also complicate sleep, nutrition, adherence to prenatal care, and mental health.

Body weight and nutrition can contribute as well. Obesity is associated with a higher likelihood of gestational diabetes, hypertensive disorders, and operative delivery, although it is not a diagnosis and it does not determine an outcome by itself. Conversely, undernutrition or severe weight loss can also be concerning because pregnancy requires adequate energy and micronutrient reserves. Medication exposure is another area where careful review matters. Some drugs are needed and safe, but others require adjustment before conception or early in pregnancy.

Social and environmental context can influence risk too. People who have unstable housing, limited access to transportation, food insecurity, or difficulty attending visits may experience delayed diagnosis of complications. Supportive, nonjudgmental care helps here: the goal is to identify barriers early and connect them with the right resources, not to assign blame.

Infections that can increase maternal-fetal risk

Infections are an important category because they can affect both the pregnant

person and the fetus, sometimes in subtle ways. HIV is a classic example: with appropriate care, outcomes are much better than they once were, but the infection still requires specialized management. Zika exposure remains relevant in travel counseling because of its association with fetal injury. Other infections can matter too, especially when they are untreated, recurrent, or associated with fever and inflammation.

Screening is a major part of prevention. For instance, asymptomatic bacteriuria in pregnancy can be clinically important even when a person has no urinary symptoms, because untreated urinary infection may ascend and cause kidney infection or other complications. Prompt evaluation of urinary burning, fever, flank pain, abnormal discharge, or exposure concerns can help clinicians decide what testing is needed. Good hygiene, food safety, safer sex practices, travel counseling, and up-to-date immunization review all contribute to lowering infectious risk, but they do not replace professional assessment.

Because infection-related risk often depends on timing, severity, and the specific organism, it is best handled individually. If there is any uncertainty about exposure, testing, or treatment in pregnancy, a clinician should guide the next step rather than relying on general internet advice.

What higher risk means for care planning

Being identified as higher risk does not mean something will go wrong. It means the care plan may need to be more specific. High-risk pregnancy surveillance may include more frequent office visits, blood pressure checks, laboratory studies, fetal growth ultrasound, or referral to maternal-fetal medicine. The exact plan depends on the combination of factors involved, how severe they are, and whether they are stable.

Planning can begin before conception when possible. Optimizing blood pressure, glucose, and thyroid function; reviewing medications; addressing smoking or alcohol use; and discussing prior complications can all reduce uncertainty. If risk factors are discovered during pregnancy, the next step is usually not panic but coordinated follow-up. Care teams may adjust the frequency of visits, watch for warning signs, and prepare for delivery in a setting that matches the level of risk.

One reassuring principle is that risk is often manageable when it is recognized early. Many complications are easier to prevent or lessen when people have timely prenatal care, clear communication, and a plan for escalation if symptoms change. If you are uncertain about your own risk profile, ask your obstetric clinician what is driving the concern and what monitoring they recommend.