Place patient ID sticker here

PREGNANCY HISTORY

How many total pregnancies have you had? _____
How many full term? (more than 9 months) _____
How many premature? (between 20 weeks-9 months) _____
How many terminations? _____ Miscarriages? _____
Any pregnancies in your tubes (ectopic)? _____ Multiple births? _____
How many of your children are living? _____ Any step-children? _____

Date of Birth Month/Year	# of weeks	Length of labor	Birth weight	Sex of baby	Type of delivery (vaginal, C/S, etc)	Anesthesia (none, epidural, etc.)	Place of delivery & provider's name	Complications

MENSTRUAL HISTORY

When was the first day of your last period? _____
Are your periods monthly? _____ How far apart are your periods? _____days
Did you have a positive home or office pregnancy test? _____ Date: _____

PAST MEDICAL HISTORY Do you have a history of:

Diabetes	Y/N	Rh Negative Blood Sensitization	Y/N
High Blood Pressure	Y/N	Asthma, TB, or pulmonary problems	Y/N
Heart Disease	Y/N	Drug Allergies If yes, to what:_____	
Autoimmune Disorders	Y/N	Breast disease or surgery	Y/N
Kidney Disease or UTIs	Y/N	Gynecologic (Female organ) surgery	Y/N
Seizure Disorder	Y/N	Hospitalizations (Year/Reason) _____	
Psychiatric Illness	Y/N	Anesthesia Complications	Y/N
Hepatitis/Liver Disease	Y/N	Abnormal Pap Smears	Y/N
Blood Clots	Y/N	Uterine abnormalities or exposure to DES	Y/N
Thyroid Disease	Y/N	Infertility	Y/N
Trauma or Domestic Violence	Y/N	Family history of medical problems _____	
Blood Transfusion	Y/N	Any additional pertinent history: _____	

Tobacco Use	Y/N	packs/day prior to pregnancy _____	during _____
Alcohol Use	Y/N	drinks/day prior to pregnancy _____	during _____
Street Drugs	Y/N	type/amount prior to pregnancy _____	during _____

Additional comments or concerns:

OBSTETRICS, GYNECOLOGY & MENOPAUSE PHYSICIANS, P.C.

Place patient ID

GENETIC SCREENING (includes patient, father of baby or anyone in either family)

Will you (the patient) be greater than 35 years old at time of delivery? Y/N

Anyone in either family have Thalassemia? (circle all that apply) Italian, Greek, Mediterranean, Asian

Any family history of:

- Neural tube defects (abnormality of the brain or spine)? Y/N
- Heart defects from birth Y/N
- Down Syndrome Y/N
- Tay-Sachs (disorder that causes blindness, mental retardation, and death in infancy) Y/N
- Canavan Disease (inherited disorder that causes progressive damage to nerve cells in the brain) Y/N
- Sickle Cell Disease or Trait (most common in people from Africa, South or Central America, Caribbean islands, Mediterranean countries -such as Turkey, Greece, and Italy-, India, and Saudi Arabia) Y/N
- Hemophilia? Y/N
- Muscular Dystrophy? (a disease characterized by severe muscle weakness and atrophy) Y/N
- Cystic Fibrosis? (a disorder that causes thick mucus production & obstruction of the intestinal glands, pancreas, and bronchi of the lungs) Y/N
- Huntington's Chorea? (a mental disorder that starts around age 40 and causes slowly declining mental function and abnormal movements) Y/N
- Mental retardation/autism? Y/N If yes, was the person tested for Fragile X? Y/N
- Other inherited genetic or chromosomal disorders? Y/N

Do you (the patient) have a metabolic disorder (ie; insulin dependent diabetes, PKU)? Y/N

Do you or the baby's father have a child with a birth defect that is not listed above? Y/N

INFECTION HISTORY

Are you at high risk for Hepatitis B: recent immigrant, multiple sexual partners, IV drug use? Y/N

Do you live with someone with tuberculosis or have been exposed to tuberculosis? Y/N

Have you had a rash or viral illness since your last menstrual period? Y/N

Do you or your partner have a history of genital herpes? Y/N

Do you have a history of any sexually transmitted infection such as gonorrhea, chlamydia, HPV, genital warts, or syphilis? Y/N

Do you or your partner have a history of HIV/AIDS? Y/N

Have you had the chicken pox or the vaccine? Y/N

Other significant infection history? Y/N