Date:____________________

Name of Patient:____

Date of Birth:______________________________Age:______________

GENETIC SCREENING

Includes Patient, Father of baby, or anyone in either family

	YES	NO		YES	NO
1.Patient age 35 or older at delivery date			11.Muscular Dystrophy		
2.Thalassemia history			12.Cystic Fibrosis		
3.Neural Tube defect			13.Huntington's Chorea		
4.Congenital Heart Defect			14.Mental Retardation/Autism (if yes was this person tested for Fragile X)		
5.Down syndrome history			15.Other inherited genetic or chromosomal disorders		
6.Tay-Sachs history			16.Maternal Metabolic Disorder (EG, Type 1 Diabetes, PKU)		
7.Canavan disease			17.Other children with birth defects not listed		
8.Familial dysautonomia			18.Recurrent pregnancy loss or a stillbirth		
9.Sickle cell disease or trait			19.Medications (Including supplements, vitamins, herbs, over the counter drugs, or recreational drugs)		
10.Hemophilia or other blood disorders			20.Any other		

Patient/Father of baby Infection History

	YES	NO		YES	NO
Live with someone with TB or exposed			Hepatitis B or C exposure		
History of genital herpes			History of gonorrhea, chlamydia, HPV, syphilis, HIV or other STI		
Rash or viral illness since last menses			Other (see comment)		

Spouse/Emergency Contact Name:________________________________

Spouse/Emergency Contact Phone: Cell______________Work________________

Race/Nationality Patient:__________Race/Nationality of Father of Baby____________

Marital Status: **S** **M** **D** **W**

Menstrual History

Date of Last Menstrual Period:______________________________

Age at Onset of First Period:______________________________

Frequency of Periods: Every__________days. Duration____________________days.

On Birth Control at Conception:___________ Date Last Used:___________________

Medication Allergies

Allergy:	Reaction:

Latex Allergy: **Y** **N**

In case of an emergency will you allow a blood transfusion? **Y** **N**

Current Medications

Medication Name:	Dose:	Length of Time on Med:

Patient's Medical History

Do you have any of the following?

	+	If yes, describe:		+	If yes, describe:
1.Diabetes			13.Rh sensitized		
2.High blood pressure			14.Pulmonary disease		
3.Heart disease			15.Gyne surgeries		
4.Autoimmune disease			16.Hosp/surgeries		
5.Kidney disease			17.Anesthesia complications		
6.Neurological			18.Abnormal pap		
7.Psychiatric/post partum depression			19.Uterine anomalies		
8.Hepatitis/liver			20.Infertility/ART treatment		
9.Vascular disease			21.Childhood vaccine		
10.Thyroid disease			22.Domestic abuse		
11.Trauma/violence			30.Other		
12.Blood transfusion					

History Since Last Period

Circle all that apply

1.Headache	2.Nausea/vomiting	3.Abdominal pain	4.Urinary complaints	5.Vaginal discharge
6.Vaginal bleeding	7.Edema(swelling)	8.Fever	9.Rubella	10.Other viral exp
11.Drug Exposure	12.Radiation exp	13.Industrial Toxin exp	14.Other	

Pre-pregnancy Weight____________________**Height**____________________

Pregnancy History

Include births,miscarriages, terminations

Month/year of birth	Weeks at delivery	Length of labor	Birth weight	Sex: M/F	Type of delivery	Name	Problems or complications

Signature____**Date**____________________