



Patient Account # _____ Date _____

Patient's Name _____
Last First Middle

Please check off if you or your blood relatives (NOT the baby's father's side of the family) have any of the following medical conditions and list which relatives have these medical conditions:

SELF FAMILY

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- Diabetes _____
- High blood pressure _____
- Heart disease _____
- Autoimmune disorder (e.g. Lupus) _____
- Kidney disease or urinary tract infections _____
- Neurologic disease or epilepsy _____
- Psychiatric disorder _____
- Depression or postpartum depression _____
- Hepatitis or liver disease _____
- Abnormal blood clots in the legs or lungs _____
- Varicose veins or phlebitis _____
- Thyroid problems _____

- History of major accidents _____
- History of blood transfusion _____
- Rh Sensitization _____
- Asthma, TB or other lung problems _____
- Seasonal allergies _____
- Breast disease _____
- History of abnormal pap smears _____
- Uterine abnormalities _____
- Infertility ____ Any infertility treatment? _____
- Phenylketonuria _____
- Any kind of complication related to anesthesia _____

Have you ever been hospitalized, except for childbirth? YES NO

If Yes, When? _____ Why? _____

Have you had any type of gynecologic surgery? YES NO

If Yes, When? _____ Why? _____

Have you had any other surgery? YES NO

If Yes, When? _____ Why? _____

Please list any medications, including vitamins and herbal remedies, that you are taking or have recently stopped taking.

Are you allergic to any medications? YES NO

To Latex? YES NO

To Betadine/Iodine? YES NO

Please list medications you are allergic to: _____

Will you be 35 or older by the time the baby is born? YES NO

What is your ethnic background? (e.g. Italian, Irish, etc) _____

- Please check all that apply: African Ashkenaz/Jewish Asian Cajun Caucasian
 French Canadian Hispanic Mediterranean (Italian, Greek, etc.)

Is there a history of the following genetic disease in either you, the baby's father, relative of either side of the family, and if so, who has the condition?

- YES NO Thalassemia (Found in Italian, Greek, Mediterranean, Asian backgrounds) _____
- YES NO Neural tube defects (spine doesn't close properly) _____
- YES NO Born with heart defect _____
- YES NO Down Syndrome _____

Is there a history of the following genetic disease in either you, the baby's father, relative of either side of the family, and if so, who has the condition?

- YES NO Tay Sachs (Ashkenazi Jewish, Cajun, French Canadian) _____
- YES NO Canavan Disease (Ashkenazi Jewish) _____
- YES NO Familial Dysautonomia (Ashkenazi Jewish) _____
- YES NO Sickle Cell Disease (African) _____
- YES NO Hemophilia or other blood disorders _____
- YES NO Muscular Dystrophy _____
- YES NO Cystic Fibrosis (More common in Caucasians) _____
- YES NO Huntington's Chorea _____
- YES NO Mental Retardation, Autism (If yes, was the person tested for Fragile X?) _____
- YES NO Other inherited or Chromosomal disorder _____
- YES NO Other birth defects _____
- YES NO Recurrent pregnancy loss or stillbirth _____

How old were you when you started your periods? _____

Are your periods regular? YES NO

How many days from the start of one to the start of the next? _____

How many days do they last? _____

When was your last menstrual period? _____

How sure are you of this date? _____

Please complete for each pregnancy:

Date	# of weeks at delivery	Length of labor	Birth Weight	Sex (Male or Female)	Vaginal? or C-Section	Place of Delivery	Comments/Complications, such as Preterm Labor, Diabetes, High Blood Pressure

Please let us know if you had any miscarriages, tubal pregnancies, or abortions, when they occurred, and any other details you think we might need to know.

- Do you smoke? YES NO How many a day? _____
- Do you drink alcohol? YES NO Amount _____
- Do you use recreational or illegal drugs? YES NO Which? _____ Amount _____
- Are you exposed to cats and/or cat litter boxes? YES NO
- Do you live with someone with TB or have you been exposed to TB? YES NO
- Do you or your partner have a history of genital herpes? YES NO
- Have you had a rash or viral illness since your last menstrual period? YES NO
- Is there a history of gonorrhea, chlamydia, HPV, HIV, syphilis? YES NO

What is your occupation? _____

- Do you work near: Children YES NO Infectious diseases YES NO Cats YES NO
- Rodents YES NO Radiation YES NO Other hazards YES NO

Have you had Chicken Pox? YES NO

Would you accept a blood transfusion if medically recommended to save your life? YES NO

Has anyone close to you ever hurt you? YES NO

Do you currently feel safe where you live? YES NO