

Medical History

- Y N 1. Do you have a seizure disorder?
- Y N 2. Do you have any history of metabolic disorders? (i.e diabetes, insulin resistance, or thyroid problems)?
- Y N 3. Have you ever had blood clots in your legs or chest?
- Y N 4. Have you ever had a mental health diagnosis?
- Y N 5. Do you have any history of drug or alcohol abuse?
- Y N 6. Do you have any chronic medical problems (i.e high blood pressure, asthma, hepatitis, or heart disease)?

Other: _____

Infection Screening

- Y N 1. Have you ever had chicken pox or varicella vaccine?
- Y N 2. Is there any exposure to tuberculosis (TB)?
- Y N 3. Do you have any history of sexually transmitted diseases (STD) exposure?
- Y N 4. Do you or your partner have a history of genital herpes?

Genetic Screening (Includes patient, baby's father, and anyone in either family)

- | | |
|---|---|
| <input type="checkbox"/> Y <input type="checkbox"/> N 1. Thalassemia | <input type="checkbox"/> Y <input type="checkbox"/> N 8. Hemophilia or Blood Disorder |
| <input type="checkbox"/> Y <input type="checkbox"/> N 2. Neural Tube Defect | <input type="checkbox"/> Y <input type="checkbox"/> N 9. Muscular Dystrophy |
| <input type="checkbox"/> Y <input type="checkbox"/> N 3. Congenital Heart Defect | <input type="checkbox"/> Y <input type="checkbox"/> N 10. Cystic Fibrosis |
| <input type="checkbox"/> Y <input type="checkbox"/> N 4. Down Syndrome | <input type="checkbox"/> Y <input type="checkbox"/> N 11. Huntington's Chorea |
| <input type="checkbox"/> Y <input type="checkbox"/> N 5. Tay-Sachs | <input type="checkbox"/> Y <input type="checkbox"/> N 12. Mental Handicap |
| <input type="checkbox"/> Y <input type="checkbox"/> N 6. Canavan's Disease | <input type="checkbox"/> Y <input type="checkbox"/> N 13. Other Chromosomal Disorder |
| <input type="checkbox"/> Y <input type="checkbox"/> N 7. Sickle Cell Disease or Trait | <input type="checkbox"/> Y <input type="checkbox"/> N 14. Other Birth Defect |

Pregnancy Summary

_____ # of Pregnancies _____ # of Premature _____ # of Abortions _____ # of Twins/Multiples
 _____ # of Full Term _____ # of Miscarriages _____ # of Ectopic/Tubal _____ # of Living Children

Date of Delivery	Weeks at Time of Delivery	Hours of Labor	Birth Weight	Sex of Child	Type of Delivery	Epidural/Anesthesia	Doctor's Name

Y=Yes N=No

YES NO History of Pregnancy Complications

- Y N 1. Any history of recurrent miscarriages, a stillbirth, or a placental abruption?
- Y N 2. Any history of preterm labor or contractions?
- Y N 3. Any history of preterm delivery <37 weeks or water breaking?
- Y N 4. Any history of a baby that weighed less than 5 ½ pounds?
- Y N 5. Any history of twins, triplets, or quads?
- Y N 6. Any history of high blood pressure with pregnancy?
- Y N 7. Any history of diabetes with pregnancy?
- Y N 8. Any history of an ectopic/tubal pregnancy?