

DATE _____
 NAME _____
 LAST FIRST MIDDLE

NEWBORN'S PHYSICIAN _____ REFERRED BY _____

FINAL EDD		PRIMARY PROVIDER/GROUP ADDRESS	
BIRTH DATE	AGE	RACE	MARITAL STATUS
OCCUPATION		EDUCATION	
LANGUAGE		ETHNICITY	
HUSBAND/DOMESTIC PARTNER		PHONE	
FATHER OF BABY		PHONE	
TOTAL PREG	FULL TERM	PREMATURE	AB. INDUCED
AB. SPONTANEOUS		ECTOPICS	MULTIPLE BIRTHS
LIVING			

MENSTRUAL HISTORY

PAST PREGNANCIES (LAST SIX)

DATE MONTH/ YEAR	GA WEEKS	LENGTH OF LABOR	BIRTH WEIGHT	SEX M/F	TYPE DELIVERY	ANES.	PLACE OF DELIVERY	PRETERM LABOR YES/NO	COMMENTS/ COMPLICATIONS

MEDICAL HISTORY

	0 Neg. + Pos.	DETAIL POSITIVE REMARKS INCLUDE DATE & TREATMENT		0 Neg. + Pos.	DETAIL POSITIVE REMARKS INCLUDE DATE & TREATMENT
1. DIABETES			17. D (Rh) SENSITIZED		
2. HYPERTENSION			18. PULMONARY (TB. ASTHMA)		
3. HEART DISEASE			19. SEASONAL ALLERGIES		
4. AUTOIMMUNE DISORDER			20. DRUG/LATEX ALLERGIES/ REACTIONS		
5. KIDNEY DISEASE/UTI			21. BREAST		
6. NEUROLOGIC/EPILEPSY			22. GYN SURGERY		
7. PSYCHIATRIC			23. OPERATIONS/ HOSPITALIZATIONS (YEAR & REASON)		
8. DEPRESSION/POSTPARTUM DEPRESSION			24. ANESTHETIC COMPLICATIONS		
9. HEPATITIS/LIVER DISEASE			25. HISTORY OF ABNORMAL PAP		
10. VARICOSITIES/PHLEBITIS			26. UTERINE ANOMALY/DES		
11. THYROID DISFUNCTION			27. INFERTILITY		
12. TRAUMA/VIOLENCE			28. ART TREATMENT		
13. HISTORY OF BLOOD TRANSFUS.			29. RELEVANT FAMILY HISTORY		
14. TOBACCO			30. OTHER		
15. ALCOHOL					
16. ILLICIT/RECREATIONAL DRUGS					

COMMENTS _____

NAME _____
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GENETIC SCREENING/TERATOLOGY COUNSELING
 INCLUDES PATIENT, BABY'S FATHER, OR ANYONE IN EITHER FAMILY WITH:

	YES	NO		YES	NO
1. PATIENT'S AGE 36 YEARS OR OLDER AS OF ESTIMATED DATE OF DELIVERY			13. HUNTINGTON'S CHOREA		
2. THALASSEMIA (ITALIAN, GREEK, MEDITERRANEAN, OR ASIAN BACKGROUND): MCV LESS THAN 80			14. MENTAL RETARDATION/AUTISM		
3. NEURAL TUBE DEFECT (MENINGOMYELOCELE, SPINA BIFIDA, OR ANENCEPHALY)			IF YES, WAS PERSON TESTED FOR FRAGILE X?		
4. CONGENITAL HEART DEFECT			15. OTHER INHERITED GENETIC OR CHROMOSOMAL DISORDER		
5. DOWN SYNDROME			16. MATERNAL METABOLIC DISORDER (EG. TYPE 1 DIABETES, PKU)		
6. TAY-SACHS (ASHKENAZI JEWISH, CAJUN, FRENCH CANADIAN)			17. PATIENT OR BABY'S FATHER HAD A CHILD WITH BIRTH DEFECTS NOT LISTED ABOVE		
7. CANAVAN DISEASE (ASHKENAZI JEWISH)			18. RECURRENT PREGNANCY LOSS, OR A STILLBIRTH		
8. FAMILIAL DYSAUTONOMIA (ASHKENAZI JEWISH)			19. MEDICATIONS (INCLUDING SUPPLEMENTS, VITAMINS, HERBS OR OTC DRUGS)/ILLICIT/RECREATIONAL DRUGS/ALCOHOL SINCE LAST MENSTRUAL PERIOD		
9. SICKLE CELL DISEASE OR TRAIT (AFRICAN)			IF YES, AGENT(S) AND STRENGTH/DOSAGE		
10. HEMOPHILIA OR OTHER BLOOD DISORDERS			20. ANY OTHER		
11. MUSCULAR DYSTROPHY					
12. CYSTIC FIBROSIS					

COMMENTS/COUNSELING _____

INFECTION HISTORY	YES	NO		YES	NO
1. LIVE WITH SOMEONE WITH TB OR EXPOSED TO TB			6. HISTORY OF CHLAMYDIA		
2. PATIENT OR PARTNER HAS HISTORY OF GENITAL HERPES			7. HISTORY OF HPV		
3. RASH OR VIRAL ILLNESS SINCE LAST MENSTRUAL PERIOD			8. HISTORY OF HIV		
4. HEPATITIS B, C			9. HISTORY OF SYPHILIS		
5. HISTORY OF GONORRHEA			10. OTHER (SEE COMMENTS)		

COMMENTS _____

Please answer Yes if you have ever had the conditions listed below, and No if you have no history of the condition

(circle Yes or No)

Recent LEEP procedure	Yes	No
Diabetes	Yes	No
Hypertension	Yes	No
Heart Disease	Yes	No
Auto-Immune Disorder	Yes	No
Kidney Disease/UTI	Yes	No
Neurological/Epilepsy	Yes	No
Psychiatric	Yes	No
Depression/Postpartum Depression	Yes	No
Hepatitis/Liver Disease	Yes	No
Varicosities/Phlebitis	Yes	No
Thyroid Dysfunction	Yes	No
Trauma/Violence	Yes	No
History of Blood Transfusion	Yes	No
Tobacco	Yes	No
Alcohol	Yes	No
Illicit/Recreational Drugs	Yes	No
D (RH) Sensitized	Yes	No
Pulmonary (TB. Asthma)	Yes	No
Seasonal Allergies	Yes	No
Drug/Latex Allergies/Reactions	Yes	No
Breast	Yes	No
Gyn Surgery	Yes	No
Operations/Hospitalizations	Yes	No
Anesthetic Complications	Yes	No
History of Abnormal Pap	Yes	No
Uterine Anomaly/DES	Yes	No
Infertility	Yes	No
Art Treatment	Yes	No
Relevant Family History	Yes	No
Other	Yes	No