Medical History: (Please check next to all that apply)

Drug/Latex Allergies? Yes________________________ No

Allergies to food/seasonal/environmental? Yes_______________________ No

1. Neurologic/Epilepsy
2. Thyroid Dysfunction
3. Breast Disease
4. Pulmonary (TB/Asthma)
5. Heart Disease
6. Hypertension
7. Cancer
8. Hematologic Disorders
9. Anemia
10. Gastrointestinal Disorders
11. Hepatitis/Liver Disease
12. Kidney Disease/UTI
13. Varicosities/Phlebitis
14. Diabetes (Type 1 or Type 2)
15. Gestational Diabetes
16. Autoimmune Disorders
17. Dermatologic Disorders
18. Operations/Hospitalizations (year & reason)

    ____

    ____

19. Gynecological Surgery
20. Anesthetic Complications
21. History of Blood Transfusion
22. Infertility
23. Assisted Reproductive Technology
24. Uterine Anomaly
25. History of Abnormal Pap Smear
26. History of STI (sexually transmitted infection)
27. Psychiatric Illness
28. Depression/Postpartum Depression
29. Trauma/ Violence
30. Tobacco (amt/day): Pre-preg _______ Preg _______ Years Used _______
31. Alcohol (amt/day): Pre-preg _______ Preg _______ Years Used _______
32. Illicit/Recreational

Drugs (times/wk): Pre-preg _______ Preg _______ Years Used _______

33. Relevant Family History (not listed):

____

____

Genetic Screening/Teratology Counseling
(Includes patient, baby's father, or anyone in either family with:

1. Thalassemia (blood disorder affecting Italian, Greek, Mediterranean or Asian background) MCV less than 80. Yes No
2. Neural Tube Defects (Meninigomyelocele, spina bifida, anencephaly) Yes No
3. Congenital Heart Defect Yes No
4. Down Syndrome Yes No
5. Tay-Sachs (affects Ashkenazi Jewish, Cajun, French Canadian) Yes No
6. Canavan Disease (affects Ashkenazi Jewish) Yes No
7. Familial Dysautonomia (affects Ashkenazi Jewish) Yes No
8. Sickle Cell Disease or Trait (affects African-American) Yes No
9. Hemophilia/Other Blood Disorders Yes No
10. Muscular Dystrophy Yes No
11. Cystic Fibrosis (lung disease) Yes No
12. Huntington Chorea Yes No
13. Mental Retardation/Autism Yes No Test for Fragile-X? Y N
14. Other Inherited Genetic or Chromosomal Disorder: _______________
15. Maternal Metabolic Disorder (Type 1 Diabetes, PKU) Yes No
16. Birth Defects Not Listed Above: _______________
17. Recurrent Pregnancy Loss or a Stillbirth Yes No
18. Taking Any Medications:

____

____

Infection History

1. Live with someone with TB or exposed to TB (Tuberculosis) Yes No
2. Patient or partner has history of genital herpes Yes No
3. Rash or viral illness since last menstrual period Yes No
4. Prior GBS infected child Yes No
5. History of STI's: Gonorrhea, Chlamydia, HPV, Syphilis, PID (circle all that apply) Yes No
6. History of HIV Yes No
7. History of Hepatitis Yes No
8. Other: _______________