

TODAY'S DATE _____

PREFERRED CONTACT NUMBER _____

NAME _____
LAST FIRST MIDDLE

BIRTHDATE	AGE	RACE	MARITAL STATUS	ADDRESS	
OCCUPATION			HIGHEST EDUCATION / GRADE COMPLETED		ZIP
LANGUAGE			ETHNICITY		PHONE (H) (O)
HUSBAND /DOMESTIC PARTNER			PHONE		INSURANCE CARRIER / MEDICAID POLICY #
FATHER OF BABY			PHONE		EMERGENCY CONTACT PHONE
TOTAL PREGNANCY _____		FULL TERM _____		PRETERM _____	
MISCARRIAGE _____		ECTOPIC/TUBAL PREGNANCY _____		MULTIPLE BIRTHS _____	
				ELECTIVE ABORTION _____	
				THERAPEUTIC ABORTION _____	
				LIVING _____	

MENSTRUAL HISTORY

THE FIRST DAY OF YOUR LAST MENSTRUAL PERIOD (LMP) WAS _____ HOW OFTEN DO YOU GET YOUR PERIOD? EVERY _____ DAYS

LMP DEFINITE APPROXIMATE (MONTH KNOWN) DO YOU HAVE A MONTHLY PERIOD / MENSES? YES NO

UNKNOWN NORMAL AMOUNT/DURATION WERE YOU ON THE PILL AT THE TIME OF CONCEPTION? YES NO

FINAL AT WHAT AGE DID YOU START YOUR PERIOD? _____

PAST PREGNANCIES (LAST SIX)

MO/DAY/YEAR	GA WEEKS	LENGTH OF LABOR	BIRTH WEIGHT	SEX M/F	TYPE OF DELIVERY	ANES	PLACE OF DELIVERY	PRETERM LABOR YES/NO	COMMENTS COMPLICATION
/ /									
/ /									
/ /									
/ /									
/ /									
/ /									

MEDICAL HISTORY

	0 Neg. + Pos.	DETAIL POSITIVE REMARKS INCLUDE DATA & TREATMENT		0 Neg. + Pos.	DETAIL POSITIVE REMARKS INCLUDE DATA & TREATMENT
1. DIABETES			17. D (Rh) SENSITIZED		
2. HYPERTENSION (high blood pressure)			18. PULMONARY (TB, ASTHMA)		
3. HEART DISEASE			19. SEASONAL ALLERGIES		
4. AUTOIMMUNE DISORDER			20. DRUG/LÁTEX ALLERGIES REACTIONS		
5. KIDNEY DISEASE/UTI			21. BREAST		
6. NEUROLÓGICAL/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 DYSFUNCTION			27. INFERTILITY		
12. TRAUMA/VIOLENCE			28. INFERTILITY TREATMENT		
13. HISTORY OF BLOOD TRANSFUSION					
	AMT/DAY PREPREG	AMT/DAY PREG	# YEARS USAGE		
14. TOBACCO				29. RELEVANT FAMILY HISTORY	
15. ALCOHOL				30. OTHER	
16. ILLICIT/RECREATIONAL DRUGS					

NAME _____
 LAST FIRST MIDDLE

SYMPTOMS SINCE LAST MENSTRUAL PERIOD (LMP)	SYMPTOMS SINCE LAST MENSTRUAL PERIOD (LMP)

GENETIC SCREENING/TERATOLOGY COUNSELING

INCLUDES PATIENT, BABY'S FATHER, OR ANYONE IN EITHER FAMILY WITH:

	YES	NO		YES	NO
1. PATIENT'S AGE 35 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 OVER THE COUNTER DRUGS / ILLICIT / RECREATIONAL DRUGS/ALCOHOL SINCE LAST PERIOD):		
			IF YES, AGENT(S) AND STRENGTH/DOSAGE:		
9. SICKLE CELL DISEASE OR TRAIT (AFRICAN)					
10. HEMOPHILIA OR OTHER BLOOD DISORDERS					
11. MUSCULAR DYSTROPHY			20. ANY OTHER (See Comments)		
12. CYSTIC FIBROSIS					

INFECTION HISTORY

	YES	NO		YES	NO
1. LIVE WITH SOMEONE WITH TB OR EXPOSED TO TB			4. HEPATITIS B/C		
2. PATIENT OR PARTNER HAS HISTORY OF GENITAL HERPES			5. HISTORY OF STD: (√ ALL THAT APPLY) <input type="checkbox"/> GONORRHEA <input type="checkbox"/> CHLAMYDIA <input type="checkbox"/> HPV <input type="checkbox"/> HIV <input type="checkbox"/> SYPHILIS		
3. RASH OR VIRAL ILLNESS SINCE LAST MENSTRUAL PERIOD			6. OTHER - No		

INTERVIEWED BY _____