

Obstetrical Family History Survey

1. Are you allergic to any medications? If yes, please list:

2. Please mark any medical condition that you have or have had in the past:

- | | | | |
|-----------------------------------------|----------------------------------------------|----------------------------------------------|-------------------------------------------|
| <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Thyroid Disease | <input type="checkbox"/> Asthma | <input type="checkbox"/> Frequent Urinary |
| <input type="checkbox"/> Heart Disease | <input type="checkbox"/> High Blood | <input type="checkbox"/> Diabetes | Tract infections |
| <input type="checkbox"/> Kidney Disease | Pressure | <input type="checkbox"/> Frequent Infections | <input type="checkbox"/> Hepatitis |
| <input type="checkbox"/> Headaches | <input type="checkbox"/> Frequent Infections | <input type="checkbox"/> Arthritis or Lupus | <input type="checkbox"/> Herpes |
| <input type="checkbox"/> Blood Disease | <input type="checkbox"/> Migraine | <input type="checkbox"/> Bowel Disease | |
| <input type="checkbox"/> Depression | Headaches | | |

3. Please indicate and surgery that you have had: _____

4. Please describe any health problems or symptoms that you are having at this time: _____

Exposures Affecting Health

1. Do you smoke cigarettes? Yes No
2. Do you own or come in contact with a cat? Yes No
3. Do you drink alcoholic beverages? Yes No
4. Have you taken any medications since your last period? Yes No
5. Do you use any "recreational" drugs (i.e. cocaine, marijuana, etc.)? Yes No
6. Do you have a history of blood transfusion?
 - a. Do you or your sexual partner have a history of intravenous drug use? Yes No
 - b. Have you or your sexual partner had other sexual partners in the past 5 years? Yes No
 - c. Have you or your sexual partner had exposure to gay or bisexual males? Yes No
8. Please list any sources of chemical or radiation exposure that you have encounter: _____
9. If you are on a restricted diet, please describe: _____

Gynecologic Health History

1. When and where was your last pap smear? _____
 Have you ever had an abnormal pap smear? Yes No
 If yes, when and where were you treated? _____
 Have you ever had gonorrhea, chlamydia, herpes, or pelvic inflammatory disease? Yes No
2. What is your HIV status? _____
3. Have you ever used an IUD (intrauterine device) for contraception? Yes No
 If yes, please indicate when: _____
 Did you have any complications? Yes No
 If yes, please describe: _____
4. Do you have a history of infertility? Yes No

Obstetric Genetic Screening

The purpose of this survey is to assist your physician in giving you the best possible care.

1. Have either you or the baby's father had a baby with a birth defect?
If yes, please describe: _____

Yes No

1a. Did either you or the baby's father have a birth defect?
If yes, please describe: _____

Yes No

2. Please describe any abnormalities that have occurred in children in your family or the baby's father's family (for example, Down's syndrome or other chromosomal defect, mental retardation, emotional problems, birth defects, deformities, or inherited diseases like hemophilia, muscular dystrophy, or cystic fibrosis).

2a. How is the affected person related to you? _____

3. Do either you or the baby's father have a history of pregnancy loss?
(miscarriages or stillborn)

Yes No

3a. If yes, have either of you had genetic counseling?

Yes No

3b. If yes, have either of you had chromosomal studies?

Yes No

3c. Where and results _____

4. Some genetic problems may occur more frequently in couples with certain racial or ancestral backgrounds. Please check if either you or the baby's father is one of these backgrounds:

Jewish ancestry?

Yes No

If yes, have you had Tay Sachs screening test?

Yes No

Black?

Yes No

If yes, have you had Sickle Cell screening?

Yes No

Italian, Greek, or Mediterranean?

Yes No

If yes, have you been tested for Beta-thalassemia?

Yes No

Philippine or Southeast Asian?

Yes No

If yes, have you been tested for Alpha-thalassemia?

Yes No

5. Please indicate whether anyone in your family or the baby's family has:

Asthma Bleed Disorder Diabetes

5a. If yes, how is that person related to you? _____

6. Please list any concerns you have about birth defects or inherited disorders: _____

7. Will you be 35 or older at the time the baby is born?

Yes No

8. Is there a family history of allergies or heart disease (including high blood pressure)?

Yes No

9. Please list any other concerns you have relative to your past health history. _____

Patient Signature

Print Name

Date