

Updated 10/24/11

Name:		Date:	
Husband's Name:		Complaints since last menstrual period:	
Cycles:	<input type="checkbox"/> Regular <input type="checkbox"/> Irregular	What symptoms have you experienced:	
Date of last pap smear:	<input type="checkbox"/> Normal <input type="checkbox"/> Abnormal		
Type of pregnancy test:	<input type="checkbox"/> Blood <input type="checkbox"/> Urine		
When was pregnancy test performed:	# Days	Past medical conditions:	
Quantity of menses:	<input type="checkbox"/> Very light <input type="checkbox"/> Normal <input type="checkbox"/> Light <input type="checkbox"/> Heavy		
Number of pregnancies:	Maternal Hx:		
	<input type="checkbox"/> Gestational Diabetes <input type="checkbox"/> Preclampsia <input type="checkbox"/> Preterm labor <input type="checkbox"/> Hypertension <input type="checkbox"/> Eclampsia <input type="checkbox"/> Preterm delivery <input type="checkbox"/> Pregnancy induced hypertension <input type="checkbox"/> Hyperemesis gravidarum <input type="checkbox"/> An incompetent cervix		
Substance use:	<input type="checkbox"/> Alcohol <input type="checkbox"/> Cocaine <input type="checkbox"/> Amphetamines <input type="checkbox"/> Tobacco <input type="checkbox"/> Marijuana <input type="checkbox"/> Street drugs	Cats:	<input type="checkbox"/> Inside <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Outside
Weight changes:	<input type="checkbox"/> Weight gain # of pounds: <input type="checkbox"/> Weight loss	Close contact with children: <input type="checkbox"/> No <input type="checkbox"/> Yes	
Domestic violence:	<input type="checkbox"/> No <input type="checkbox"/> Yes	Chicken pox: <input type="checkbox"/> No <input type="checkbox"/> Yes	
Patients age > / = 35 at EDC:	<input type="checkbox"/> No <input type="checkbox"/> Yes	Cystic fibrosis: <input type="checkbox"/> No <input type="checkbox"/> Yes	
Thalassemia MCV < 80:	<input type="checkbox"/> Italian <input type="checkbox"/> Mediterranean <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Greek <input type="checkbox"/> Asian	Huntington's Chorea: <input type="checkbox"/> No <input type="checkbox"/> Yes	
Neural tube defect:	<input type="checkbox"/> Spina bifida <input type="checkbox"/> Meningomyelocele <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Anencephaly	Mental retardation/autism: If yes, person tested for Fragile X:	<input type="checkbox"/> No <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Yes
Congenital heart defect:	<input type="checkbox"/> No <input type="checkbox"/> Yes	Other inherited genetic or chromosomal disorder: <input type="checkbox"/> No <input type="checkbox"/> Yes	
Down syndrome:	<input type="checkbox"/> No <input type="checkbox"/> Yes	Maternal metabolic disorder:	<input type="checkbox"/> DM <input type="checkbox"/> Other: <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> PKU
Tay-Sachs:	<input type="checkbox"/> Jewish <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> French Canadian	Patient or FOB with a child with a birth defect not listed above: <input type="checkbox"/> No <input type="checkbox"/> Yes	
Canavan's Disease:	<input type="checkbox"/> No <input type="checkbox"/> Yes	Patient or FOB with a birth defect themselves: <input type="checkbox"/> No <input type="checkbox"/> Yes	
Sickle cell disease or trait:	<input type="checkbox"/> African <input type="checkbox"/> No <input type="checkbox"/> Yes	Recurrent pregnancy loss, or stillbirth: <input type="checkbox"/> No <input type="checkbox"/> Yes	
Hemophilia or other blood disorders:	<input type="checkbox"/> No <input type="checkbox"/> Yes	Any medications since LMP other than prenatal vitamins: <input type="checkbox"/> No <input type="checkbox"/> Yes (include vitamins, supplements, OTC meds, drugs, alcohol)	
Muscular dystrophy:	<input type="checkbox"/> No <input type="checkbox"/> Yes	Any other genetic/environmental exposure to discuss: <input type="checkbox"/> No <input type="checkbox"/> Yes	
Lives with someone with TB or TB exposed:	<input type="checkbox"/> No <input type="checkbox"/> Yes	Rash or viral illness since LMP: <input type="checkbox"/> No <input type="checkbox"/> Yes	
Patient or partner has history of genital herpes:	<input type="checkbox"/> No <input type="checkbox"/> Yes	History of STD: <input type="checkbox"/> No <input type="checkbox"/> Yes	