Name________________________________ DOB___________ Date____________ PT #______________________

Patient phone #: _____________________________ Patient Occupation: ___________________________________

Husband/Domestic Partner (Name): _____________________ Occupation: ___________________________________

Pediatrician Name: ____

Date of first positive pregnancy test? ________________ Date of last menstrual period?_________________________

Cycles occur every______days, lasting for______days. Last menstrual period normal? [ ] Yes [ ] No

If no, how was it different? ____

On Birth Control Pills when you conceived? [ ] Yes [ ] No Height __________ Pre-pregnant Weight___________

Date of last Pap smear ________________________ Result____

Allergies to Medications [ ] Yes [ ] No Please list: _____________________________________
Allergies to Latex [ ] Yes [ ] No Is blood transfusion acceptable? [ ] Yes [ ] No

List all medications taken since the first day of last period including supplements, vitamins, herbs, and OTC.

Drug Name	**Strength (eg. IU's, milligrams, micrograms)**	**Dosage {eg. 1 ounce per day, 1 tablet 3 times}**	**Date started \ stopped**

Pregnancy History--- Total number of pregnancies ___________

Number of pregnancies that were:

Full term ________ Premature _______ Miscarriages _______ Elective abortions _______

Ectopic Pregnancies _______ Multiple births _______ Number of living children __________

Past Pregnancy--- Please include miscarriages/abortions/tubal pregnancies

Date of Delivery	No. of weeks at Delivery	Hours of Labor	Infant Weight	Sex	Type of Delivery	Anesthesia	Place of Delivery	Complications

Patient Medical History---
Check whether you currently have or have had in the past any of the following:

[ ] Diabetes
[ ] Hypertension
[ ] Heart Disease
[ ] Autoimmune Disorder
[ ] Kidney Disease/UTI
[ ] Neurologic/Epilepsy
[ ] Psychiatric
[ ] Depression/Postpartum Dep.
[ ] Hepatitis/Liver Disease
[ ] Varicosities/Phlebitis
[ ] Thyroid Dysfunction
[ ] Trauma/Violence
[ ] History of Blood Transfusion
[ ] Rh Sensitized
[ ] Pulmonary (TB/Asthma)
[ ] Seasonal Allergies
[ ] Drug/Latex Allergies
[ ] Breast Issues
[ ] GYN Surgery
[ ] Operations/Hospitalization
[ ] Anesthetic Complications
[ ] History of Abnormal Pap
[ ] Uterine Anomaly/DES
[ ] Infertility
[ ] ART Treatment
[ ] Relevant Family History
[ ] Other

List Date & Type of Surgeries or Hospitalizations:____
____

Social History---
Do you drink alcohol? [ ] None [ ] Rarely [ ] Socially [ ] Daily Number of drinks per week________
Do you use tobacco products? [ ] Yes [ ] No Packs per day ________
Have you used any illegal or street drugs such as marijuana, cocaine, or methamphetamine since the first day of your last period? [ ] Yes [ ] No If yes, what type and how much?________________________________

Genetic Background---
Please indicate if either you, your baby's father, or anyone in either family has had any of the following:

[ ] Thalassemia (Italian, Greek, Mediterranean, or Asian background)
[ ] Neural Tube Defect (Spina Bifida, Meningomyelocele, Anencephaly)
[ ] Metabolic Disorder (Type 1 Diabetes, Galactosemia, Phenylketonuria)
[ ] Tay-Sachs Disease (Ashkenazi Jewish, Cajun, French Canadian)
[ ] Canavan Disease (Ashkenazi Jewish)
[ ] Familial Dysautonomia (Ashkenazi Jewish)
[ ] Will you be 35 years or older at the time of your baby's birth
[ ] Will the father of the baby be 55 years or older at the time of birth
[ ] You/baby's father ever had a stillborn
[ ] Muscular Dystrophy
[ ] Huntington's Chorea
[ ] Mental Retardation/Autism
  [ ] Tested for Fragile X?
[ ] Congenital heart defect
[ ] Down Syndrome
[ ] Cystic Fibrosis
[ ] Hemophilia/Blood clotting abnormalities
[ ] Sickle cell anemia

Do you or the baby's father have any birth defects not listed on previous page? [ ] Yes [ ] No

If yes, what type? ______________________________

Have you or the baby's father ever had a child with a birth defect not listed above? [ ] Yes [ ] No

If yes, what type? ______________________________

Does the father of the baby have other children not related to you? [ ] Yes [ ] No
If yes, how many? _______Girls ______Boys

Infection History---
Do you live with someone or have you been exposed to Tuberculosis? [ ] Yes [ ] No

Do you or your sexual partner have oral or genital herpes? [ ] Yes [ ] No

Have you ever had any of the following sexually transmitted diseases? ***If yes, check all that apply***

[ ] Gonorrhea [ ] Chlamydia [ ] HIV infection [ ] Syphilis [ ] HPV infection?

Have you had a rash or viral illness since your last menstrual period? [ ] Yes [ ] No

Do you have Hepatitis B virus or Hepatitis C virus? [ ] Yes [ ] No

Have you had any of the following childhood diseases or have you been vaccinated against them?

Chickenpox	[ ] Yes	[ ] No	[ ] Vaccinated
Measles	[ ] Yes	[ ] No	[ ] Vaccinated
Mumps	[ ] Yes	[ ] No	[ ] Vaccinated
Rubella	[ ] Yes	[ ] No	[ ] Vaccinated
DPT (tetanus, diphtheria, pertussis)	[ ] Yes	[ ] No	[ ] Vaccinated

Have you had Parvovirus (Fifth's disease)? [ ] Yes [ ] No

Do you have a cat or change the litter box? [ ] Yes [ ] No

Your home life---
Do you feel safe in your current living situation? [ ] Yes [ ] No
Do you feel safe with your current partner? [ ] Yes [ ] No
If you answered "no" to either of these questions, please exercise caution and do not leave this form where your partner may see it. Both you and the baby may be at risk in this situation. It is important that you protect yourself and your baby by finding a safe place.