

Medical History

Please indicate whether you have or have had any of the following

	Details:		Details:
1. Diabetes		17. Do you know your blood type?	
2. High blood Pressure		18. Pulmonary problems like Tuberculosis or asthma	
3. Heart Disease		19. Seasonal Allergies	
4. Autoimmune Disorder/ Lupus		20. Are you allergic to any medications or to Latex	
5. Kidney problems, Frequent urinary tract infections		21. Breast problems like fibrocystic breasts	
6. Neurological problems/ Epilepsy		22. Have you ever had any gynecologic surgeries like LEEPS or Cone Biopsies	
7. Psychiatric		23. Please list any Operations or Hospitalizations	
8. Depression/ Postpartum Depression		24. Problems with anesthesia	
9. Hepatitis/ Liver Diseases		25. History of Abnormal Pap smear? When was your last pap smear? Was it normal?	
10. Varicose veins/ Phlebitis		26. Uterine abnormalities	
11. Thyroid problems		27. Problems with Infertility	
12. Have you suffered any Trauma or Violence		28. Relevant Family History: Anybody in you immediate family with the above?	
13. History of Blood Transfusion		29. Other	
Do you use:	Amount used before conception:	Amount used since last period:	Number of years used:
14. Tobacco:			
15. Alcohol:			
16. Illicit/ Recreational Drugs:			

What Symptoms have you had Since your last period:

Genetic Screening/ Teratologic Counseling					
Includes Patient, Baby's Father, or Anyone in Either Family with:					
	Yes	No		Yes	No
1. Patient's Age or baby of father > or = to 35 y/o at Estimated Date of Delivery			12. Huntington's Chorea		
2. Thalassemia (Italian, Greek, Mediterranean, or Asian)			13. Mental Retardation/ Autism		
3. Neural Tube Defect (Meningomyelocele, Spina Bifida, or Anencephaly)			14. Other Inherited Genetic or Chromosomal Disorder like extra fingers, clef palette , club foot		
4. Congenital Heart Defect			15. Maternal Metabolic Disorder		
5. Down Syndrome			16. Patient or Baby's Father has a child with birth defect not listed above		
6. Tay-Sachs (Jewish, Cajun, French Canadian)			17. Recurrent Pregnancy Loss or Stillbirth		
7. Canavan Disease			18. Medications/Drugs/Alcohol Since LMP		
8. Sickle Cell Disease or Trait (African)			If Yes, Agents, Strength and Dose		
9. Hemophilia or Other Blood Disorder			19. Any Other		
10. Muscular Dystrophy					
11. Cystic Fibrosis					
Comments:					

Infection History					
	Yes	No		Yes	No
1. Live with Someone with TB or Exposed to TB			4. History of STD: Gonorrhea, HPV, Chlamydia, Syphilis		
2. Patient or Partner has History of Genital Herpes			5. Have you had chicken pox		
3. Have you had a Rash or Viral Illness Since your last period?			6. Do you have cats?		
Comments:					