Elite OB/GYN

compassionate • personalized • dedicated

Patient Name: ____________________________

Name of husband/domestic partner/father of baby: ____________________________

Pregnancy History

Delivery Date	How many weeks pregnant when you delivered	Length of labor	Birth weight	Male or Female	Vaginal (vacuum or forceps) or C-section	Epidural? (Yes/no)	Preterm labor?	Complications? i.e. diabetes, high blood pressure	Place of delivery

Genetic Screening/Teratologic Counseling—Includes Patient, Baby's Father, or Anyone in Either Family with:

	Yes	No		Yes	No
1. Patient or father of baby >35 years old at estimated time 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, cleft palate, club foot		
4. Congenital heart defect			15. Maternal metabolic disorder		
5. Down's 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 last period?		
8. Sickle Cell Disease or trait (African)			If yes to 18, agents, strength, and dose		
9. Hemophilia or other blood disorders			19. Any others		
10. Muscular Dystrophy					
11. Cystic Fibrosis					
Comments:					

Infection History

	Yes	No		Yes	No
1. Do you live with someone with TB or exposed to TB?			4. History of STD: gonorrhea, HIV, 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:					