Center for Genetics and Maternal-Fetal Medicine

MEDICAL AND FAMILY HISTORY INFORMATION

Name:_____ **Birthdate:**_____ **Birthplace:**_____

Maiden Name: _____ **Occupation:**_____ **Current Age:** ____ **Age at Due Date:** ____

Are You Pregnant? Yes / No **Infertility Problems?** _____ **Was Birth Control Used?** Yes / No

Was This Pregnancy Conceived Using: [ ] Artificial Insemination [ ] Egg Donation [ ] Anonymous Donor

Are you and your partner related to each other, except by marriage (example: cousins)? Yes / No

Jewish Ancestry: Yes / No **Religious Preference:** _____ **Ethnicity:** Hispanic/Latino? [ ] Yes [ ] No

Race (check 1 or more): [ ] White/Caucasian [ ] Black/African-American [ ] Asian

[ ] American Indian/Alaska Native [ ] Native Hawaiian/Pacific Islander

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Partner/Spouse Name:_____ **Birthdate:**_____ **Birthplace:**_____

Occupation: _____ **Age:**____ **Major Medical Problems?** _____

Jewish Ancestry: Yes / No **Religious Preference:** _____ **Ethnicity:** Hispanic/Latino? [ ] Yes [ ] No

Race (check 1 or more): [ ] White/Caucasian [ ] Black/African-American [ ] Asian

[ ] American Indian/Alaska Native [ ] Native Hawaiian/Pacific Islander

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Patient's Past Pregnancy History including live births, miscarriages, stillbirths, terminations:

Total (including current): ____ **Term: ____** (37+ weeks) **Preterm: ____** (20-36 weeks) **Miscarriage: ____** (Below 20 weeks) **Termination: ____** (Elective abortion) **Living: ____**

Child's Name OR Miscarriage/Termination	Date/Delivery Date	Delivery Type (vaginal, c-section, etc)	Complications	Present Health	Same father as this pregnancy?
1.					
2.					
3.					
4.					
5.					
6.					
7.					
8.					
9.					
10.					

Father of Current Pregnancy (Please list all pregnancies/children with any *other* partner)

Name/Miscarriage/Termination	Birthdate/Age	Child's Present Health

Tobacco: [ ] During Pregnancy [ ] Quit for Pregnancy [ ] Past History: Quit Date _____ [ ] Never
Type: [ ] Cigarettes _____ packs/day [ ] Cigars (how often) _____ [ ] Oral/Chew (how often) _____
Alcohol: [ ] During Pregnancy [ ] Quit for Pregnancy [ ] Past History: Quit Date _____ [ ] Never
Drug Use: [ ] During Pregnancy [ ] Quit for Pregnancy [ ] Past History: Quit Date _____ [ ] Never
Type: [ ] Marijuana [ ] Cocaine [ ] Heroin [ ] Methamphetamine [ ] Other (specify) _____

During this pregnancy:

Yes	No	Unsure		Yes	No	Unsure	
____	____	____	Vaginal Bleeding (Date):_____	____	____	____	Ultrasound (Date):_____
____	____	____	Infections, Rash, or Other Illness	____	____	____	Injuries/Accidents (Date):_____
____	____	____	Fever, over 100° F	____	____	____	Chemical Exposure _____
____	____	____	X-Rays (Date): _____	____	____	____	Other:_____

Patient's Past Medical History — Please Explain "Yes" answers

Yes	No	Unsure	
____	____	____	Headaches not relieved easily with Tylenol etc _____
____	____	____	Thyroid Disease _____
____	____	____	Breast Lumps_____
____	____	____	Heart Problems_____
____	____	____	Liver Disease_____
____	____	____	Gallbladder Disease_____
____	____	____	Kidney or Bladder Problems_____
____	____	____	Bowel Problems_____
____	____	____	Vaginal Infections_____
____	____	____	Chlamydia, Gonorrhea, Syphilis (please specify)_____
____	____	____	Herpes or Genital Warts (please specify)_____
____	____	____	Pelvic Infection_____
____	____	____	Depression/Other Psychiatric Issue_____
____	____	____	Surgeries/Operations (type)_____
____	____	____	Diabetes_____
____	____	____	AIDS or Exposure to HIV_____
____	____	____	Stroke_____
____	____	____	Blood Clots_____
____	____	____	Epilepsy/Seizures_____
____	____	____	Cancer (type)_____
____	____	____	Varicose Veins _____
____	____	____	Anemia (date)_____
____	____	____	Bleeding Problems_____
____	____	____	Previous Blood Transfusions (date)_____
____	____	____	High Blood Pressure_____
____	____	____	Eating disorders (i.e. Anorexia, Bulimia)_____
____	____	____	Have you seen a specialist (if so, why) _____
			_____
____	____	____	Has anyone hit or physically harmed you _____
____	____	____	Has anyone threatened to harm you_____
____	____	____	Have you ever been sexually abused_____
____	____	____	Are you in danger during this pregnancy?_____

Patient's Family History

Please consider: children, parents, brothers, sisters, aunts, uncles, cousins, and grandparents.

Yes	No	Unsure		Please Specify
____	____	____	Birth Defects (example: Cleft Lip, Spina Bifida)	_____
				_____
____	____	____	Stillbirth or Childhood Death	_____
____	____	____	Miscarriage (three or more)	_____
____	____	____	Mental Retardation	_____
____	____	____	Chromosome Disorder (example: Down syndrome, Turner syndrome)	_____
				_____
____	____	____	Blindness	_____
____	____	____	Deafness	_____
____	____	____	Genetic Disease	_____
____	____	____	Stroke	_____
____	____	____	Blood Clots	_____
____	____	____	Heart Disease	_____
____	____	____	Diabetes	_____
____	____	____	Cancer	_____
____	____	____	Anything that seems to "run" in the family	_____
_____				

Father of the Pregnancy's Family History:

Please consider: children, parents, brothers, sisters, aunts, uncles, cousins, and grandparents.

Yes	No	Unsure		Please Specify
____	____	____	Birth Defects (example: Cleft Lip, Spina Bifida)	_____
				_____
____	____	____	Stillbirth or Childhood Death	_____
____	____	____	Miscarriage (three or more)	_____
____	____	____	Mental Retardation	_____
____	____	____	Chromosome Disorder (example: Down syndrome, Turner syndrome)	_____
				_____
____	____	____	Blindness	_____
____	____	____	Deafness	_____
____	____	____	Genetic Disease	_____
____	____	____	Stroke	_____
____	____	____	Blood Clots	_____
____	____	____	Heart Disease	_____
____	____	____	Diabetes	_____
____	____	____	Cancer	_____
____	____	____	Anything that seems to "run" in the family	_____
_____				