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

---

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

---

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	_____