

OB INFORMATION, PAGE 2

NAME _____

List all surgeries, include dates: _____

List all medications you are currently on: _____

List all allergies to medications: _____

Do you smoke? ____ if yes, list amount per day: _____

Family History: Please check if anyone in your family (brother, sisters, parent, or grandparents) have a history of the following before the age of 50.

_____ Heart disease/stroke _____	_____ Cancer _____
_____ High blood pressure _____	_____ Epilepsy _____
_____ Diabetes _____	_____ Tuberculosis _____
_____ Kidney disease _____	_____ Twins _____
_____ Thyroid disease _____	

Social History: Are you: married separated divorced single

Father of the baby: age ____ race _____

Your: age ____ race _____

Will the father of the baby be involved with prenatal visits/classes Yes No

Who else lives in your household: _____

Risk Factors:

- Yes No 1. Will you be age 35 or older when you deliver?
- Yes No 2. Have you or your partner or anyone in either of your families ever had: (describe)
 - Yes No a. Down's Syndrome (Mongolism)?
 - Yes No b. Spina Bifida or Meningomyelocele (open spine)?
 - Yes No c. Hydrocephalus (water on the brain)?
 - Yes No d. Muscular Dystrophy or Huntington's Chorea?
 - Yes No e. Hemophilia (free bleeding) other blood disorders?
 - Yes No f. Heart Defects at birth?
 - Yes No g. Cystic Fibrosis?
- Yes No 3. Have you or your partner had a child born dead or alive with a birth defect not listed in question 2 above
Describe: _____
- Yes No 4. Do you or your partner or a close relative have any inherited genetic or chromosomal disease not listed above?
Describe: _____
- Yes No 5. Do you or your partner or a close relative who are mentally retarded or have birth defects
Describe: _____
- Yes No 6. Do you or your partner or a close relative descended from Eastern European Jewish people (Ashkenzi Jews) or Cajun/French Canadian? Results if you or your partner screened for Tay Sachs: _____
- Yes No 7. If you or your partner are of Mediterranean or Asian descent, have you been screened for Thalassemia (a blood type problem) Results: _____
- Yes No 8. If you or your partner are African-American, results if either of you have been screened for sickle cell disease:
(you) _____ (your partner) _____
- Yes No 9. Have you been exposed to or live with someone who has TB or Hepatitis ?
- Yes No 10. If you own cats or other animals, do you empty the litter box?
- Yes No 11. Have you had any serious illness or fever or rash during the first 2 months of this pregnancy?
- Yes No 12. During this pregnancy have you had any use or exposure dates) to alcohol, medications, street drugs, or industrial chemicals? Describe (with dates) _____
- Yes No 13. Did you take any fertility medications to achieve this pregnancy?
- Yes No 14. Do you have any abnormality of your uterus? Describe: _____
- Yes No 15. Do you have a history of incompetent cervix or cervical cerclage? Describe: _____
- Yes No 16. Do you have a history of premature deliveries? Describe? _____
- Yes No 17. Are you Rh negative? Describe any problems with prior pregnancies: _____
- Yes No 18. Have you been tested for immunity to rubella (German measles)? Results: _____

Notes: _____