Patient Addressograph

OBSTETRIC MEDICAL HISTORY

Patient Name: _____

Date Form Completed: _____

If you are uncomfortable answering any questions, leave them blank; you can discuss them with your doctor or nurse.

PERSONAL HEALTH HISTORY

1. ☐ Yes ☐ No Are you allergic to any medications?

   If yes, please list: _____

2. Please mark any condition that you have or have had in the past:

   ☐ Cancer ☐ HIV/AIDS ☐ Diabetes
   ☐ Epilepsy ☐ Thyroid disorder ☐ Eating disorder
   ☐ Heart disease ☐ Headaches ☐ Depression
   ☐ High blood pressure ☐ Arthritis or lupus ☐ Asthma
   ☐ Kidney disease ☐ Frequent infections ☐ Anemia
   ☐ Hepatitis ☐ Bowel disease ☐ Herpes
   ☐ von Willebrand's disease or other bleeding disorders ☐ Sexually transmitted diseases
   ☐ Blood clotting disorder (eg, phlebitis) ☐ Recurrent urinary tract infections

   Describe, if needed: _____

3. Please indicate any surgery or hospitalization that you have had: _____

4. Please describe any health problems or symptoms that you are having at this time: _____

5. ☐ Yes ☐ No Do you or any family member have a history of problems with anesthesia?

   If yes, please describe: _____

6. ☐ Yes ☐ No Do you have any religious objections to any form of medical treatment (eg, refusal of blood transfusion)?

   If yes, please describe: _____

FAMILY HISTORY & GENETIC SCREENING

1. What is your ethnicity? _____ What is the ethnicity of the baby's father? _____

2. ☐ Yes ☐ No Have you or has the baby's father had a child born with a birth defect?

   If yes, please describe: _____

3. ☐ Yes ☐ No Did either you or the baby's father have a birth defect?

   If yes, please describe: _____

4. Please describe any abnormalities that have occurred in children of your family or the baby's father's family (eg, mental retardation, birth defects, early infant death, deformities, or inherited diseases such as hemophilia, muscular dystrophy, or cystic fibrosis):

   _____

   _____

   _____

   How is this child/person related to you? _____

5. ☐ Yes ☐ No Do you or does the baby's father have a history of pregnancy losses (miscarriages or stillbirths)?

   If yes, have either of you had genetic counseling? ☐ Yes ☐ No

   If yes, have either of you had chromosomal testing? ☐ Yes ☐ No

   Where and what were the results? _____

6. Some genetic problems occur more in couples with certain racial or ancestral backgrounds. Please check if you are, or the baby's father is, of one of these backgrounds:

   ☐ Yes ☐ No Eastern European Jewish (Ashkenazi) ancestry

   If yes, have you had Tay-Sachs screening tests? ☐ Yes ☐ No

   If yes, have you had a Canavan screening test? ☐ Yes ☐ No

   If yes, have you had cystic fibrosis screening? ☐ Yes ☐ No

   If yes, have you had familial dysautonomia screening? ☐ Yes ☐ No

   Date _____ Result _____

   ☐ Yes ☐ No African American

   If yes, have you had sickle cell screening? ☐ Yes ☐ No

   Date _____ Result _____

   ☐ Yes ☐ No European ancestry and Eastern European Jewish (Ashkenazi) ancestry

   If yes, have you had cystic fibrosis screening? ☐ Yes ☐ No

   ☐ Yes ☐ No Mediterranean ancestry or Southeast Asian ancestry

   If yes, have you had screening for inherited forms of anemia such as thalassemia? ☐ Yes ☐ No

7. Please list any other concerns you have about birth defects or inherited disorders:

   _____

   _____

   _____

   _____

   _____

   _____

   _____

8. ☐ Yes ☐ No Do you want to have a Down syndrome risk assessment?

9. ☐ Yes ☐ No Is the father 50 years or older?