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OBSTETRICS & GYNECOLOGY

PREGNANCY SCREENING

Patient's Name: _____ Date of Birth: _____ Blood Type: _____
Last Maiden First

Address: _____
Street City State Zip

Father's Name: _____ Date of Birth: _____ Blood Type: _____

First Day of Last Menstrual Period: _____ Result of Pregnancy Test: _____

Children (Living and Deceased) or Miscarriages:

DATE OF BIRTH	NAME	BIRTH WEIGHT	SEX	LENGTH OF LABOR	VAGINAL OR C/S	NATURAL FATHER'S NAME	ANY COMPLICATIONS

1. Do you, the baby's father, or a close relative in either of your families have a birth defect, any familial disorder, or a chromosomal abnormality? Yes _____ No _____ If yes, indicate the condition and the relationship of the affected person to you or to the baby's father.

_____

_____

2. Has there been x-ray exposure during this pregnancy? Yes ___ No ___

3. Please describe any medication taken during this pregnancy? _____

4. Has there been any history of intravenous drug use by either partner? Mother: Yes ___ No ___
Father: Yes ___ No ___
Other family member: Yes ___ No ___

5. Do you smoke? Yes ___ No ___ If so, how long? _____

6. Has there been any exposure to a sexual partner who is bi-sexual, HIV positive or had multiple sexual partners in the past?
Mother: Yes ___ No ___ Father: Yes ___ No ___

7. Has either partner been the recipient of a blood transfusion? Mother: Yes ___ No ___ Father: Yes ___ No ___

8. The U.S. Center for Disease Control has recommended that all pregnant women be screened for HIV. Our practice routinely screens all pregnant patients for HIV. If you wish to refuse screening, please notify us.

9. Have you, the baby's father or anyone in either of your families ever had any of the following disorders?

DESCRIPTION	MOTHER	FATHER	OTHER
Down's Syndrome (Mongolism)	Yes ___ No ___	Yes ___ No ___	Yes ___ No ___
Other Chromosomal Abnormality	Yes ___ No ___	Yes ___ No ___	Yes ___ No ___
Neural Tube Defect (Spina Bifida, Anencephaly)	Yes ___ No ___	Yes ___ No ___	Yes ___ No ___
Hemophilia	Yes ___ No ___	Yes ___ No ___	Yes ___ No ___
Muscular Dystrophy	Yes ___ No ___	Yes ___ No ___	Yes ___ No ___
Cystic Fibrosis	Yes ___ No ___	Yes ___ No ___	Yes ___ No ___

10. Have you, the baby's father or anyone in either of your families ever had a child born with a defect not listed above?

11. Have you, the baby's father or anyone in either of your families ever had a child stillborn?

12. Are you or the baby's father Black or Hispanic? Mother: Yes ___ No ___ Father: Yes ___ No ___ Have either of you been screened for sickle cell trait? If yes. indicate who and the results: _____

13. Are you or the baby's father of Italian, Greek or Mediterranean background? Mother: Yes ___ No ___ Father: Yes ___ No ___ Have either of you been treated for B-Thalassemia? Mother: Yes ___ No ___ Father: Yes ___ No ___
If yes, indicate who and the results: _____

14. Are you or the baby's father of Jewish ancestry? Mother: Yes ___ No ___ Father: Yes ___ No ___ If yes, have either for Tay Sachs Disease? If yes, indicate who and the results: _____

15. Do you have a cat? Yes ___ No ___

16. Will you be age 35 or older when the baby is born? Yes ___ No ___

17. Are you, the baby's father or anyone in either of your families mentally retarded? Mother: Yes ___ No ___ Father: Yes ___ No ___ Other: Yes ___ No ___

18. Do you, the baby's father or anyone in either of your families have any inherited genetic or chromosomal disease or disorder not listed above? Yes ___ No ___
If yes, describe: _____

19. Please describe how much alcohol, including beer, you have consumed during this pregnancy: _____

20. Have you or the baby's father, in a previous relationship, had two or more miscarriages? Yes ___ No ___

___ By checking this box, I acknowledge that I have been instructed to call with any further additional questions.

___ By checking this box, I recognize that obstetricians conduct basic screening for some of the more common prenatal genetic conditions. I am aware that if I desire a more comprehensive genetic evaluation, I should consult with a geneticist and/or perinatologist.

___ By checking this box, I acknowledge that I have been advised to speak to my spouse (significant other) and relatives regarding the aforementioned questions.

_____
Patient' Signature

_____
Witness

_____
Date

____By checking this box, I acknowledge that I am aware that despite all medical advances, 0.7% of newborns in the United States die shortly after birth, 3% have major structural defects, and 0.2% develop cerebral palsy.