

Obstetric Medical History

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

If yes, please describe: _____

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

If yes, please describe: _____

Yes No Are you ever exposed to chemicals or radiation (eg, X-rays)?

If yes, please describe: _____

Yes No Are you on a restricted diet?

If yes, please describe? _____

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

How is this child/person related to you? _____

Yes No Do you or the baby's father have a history of pregnancy losses (miscarriages or stillborn)?

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? _____

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

Yes No Eastern Europe Jewish ancestry

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

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

Date: _____ Results: _____

Yes No African American

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

Date: _____ Results: _____

Yes No European 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 forma of anemia such as Thalassemia? Yes No

Please list any concerns you have about birth defects of inherited disorders: _____

Yes No Will you be 35 years or older at the time the baby is born?

Yes No Will the father be 50 years or older?

Yes No Do you feel unsafe where you live?

In the past 2 months have you used any form of :

Tobacco Yes No

Alcohol Yes No What kind and when last used: _____

Drugs Yes No Which ones and when last used: _____

Yes No In the past year have you been threatened, hit, slapped or kicked by anyone you know?

Yes No Has anyone forced you to perform any sexual act that you did not want to do?

Patient Signature

Print Name

Date