NEW PREGNANCY HISTORY

Date:___________________

Last Name:__________________ First Name:______________________ DOB:___________________

First Day of Last Period:__________________ Date of First Positive Pregnancy Test :___________________

Pre-pregnancy Weight:____________________

Have You Received Any Care From Any Other Provider This Pregnancy, Including the ER? Yes / No

If Yes, Please List Where:____

Genetic Screening and Infection History

Please Answer Yes / No to the Following, Include Notes as Necessary

Patient's Age Will Be 35 Years Or Older At Estimated Date of Delivery	Y / N		Other Inherited Genetic Or Chromosomal Disorder	Y / N	
Thalassemia (Italian, Greek, Mediterranean, Or Asian Background): MCV<80	Y / N		Maternal Metabolic Disorder (eg, Type 1 Diabetes, PKU)	Y / N	
Neural Tube Defect (Meningomyelocele, Spina Bifida, Or Anencephaly)	Y / N		Patient Or Baby's Father Had A Child With Birth Defects Not Listed Prior	Y / N	
Congenital Heart Defect	Y / N		Recurrent Pregnancy Loss, Or A Stillbirth	Y / N	
Down Syndrome	Y / N		Medications (Including Supplements, Vitamins, Herbs, OTC Drugs), Illicit/Recreational Drugs, Alcohol	Y / N	
Tay-Sachs (eg, Jewish, Cajun, French-Canadian)	Y / N		If Yes, Agent(s) And Strength/Dosage	Y / N	
Canavan Disease	Y / N		Live With Someone With TB Or Exposed To TB	Y / N	
Sickle Cell Disease Or Trait	Y / N		Patient Or Partner Has History Of Genital Herpes	Y / N	
Hemophilia Or Other Blood Disorders	Y / N		Rash Or Viral Illness Since Last Menstrual Period	Y / N	
Muscular Dystrophy	Y / N		History Of STD, Gonorrhea, Chlamydia, HPV, Syphilis	Y / N	
Cystic Fibrosis	Y / N		History of HIV	Y / N	
Huntington's Chorea	Y / N		History of Hepatitis	Y / N	
Mental Retardation/Autism	Y / N		Other Infection History (eg, Chicken Pox)	Y / N	
If Yes, Was Person Tested For Fragile X?	Y / N		Prior GBS-infected child	Y / N	