New Patient Prenatal Medical History Form

Today's date_____

Appointment date _____

Name:_____
(First) (Middle) (Last)

Date of Birth: _____

Race/Ethnicity/Birthplace _____

Place of Delivery Fairview Southdale Fairview Ridges
(please circle)

LMP (Last Menstrual Period) _____

Date of 1st positive pregnancy test _____

Baby's Physician (if known)_____

Father of Baby/Partner _____

Would you accept blood products if needed ☐ Yes ☐ No

1. Are you 35 years old or over? ☐ Yes No ☐

Genetic History

2. Thalassemia	☐ Yes	No ☐	If yes, relationship to you _____
3. Neural Tube Defect (meningomyelocele, spina bifida, anencephaly)	☐ Yes	No ☐	If yes, relationship to you _____
4. Congenital Heart Disease	☐ Yes	No ☐	If yes, relationship to you _____
5. Down Syndrome	☐ Yes	No ☐	If yes, relationship to you _____
6. Tay-Sachs (Jewish, French Canadian)	☐ Yes	No ☐	If yes, relationship to you _____
7. Canavan Disease	☐ Yes	No ☐	If yes, relationship to you _____
8. Sickle Cell Disease or Trait	☐ Yes	No ☐	If yes, relationship to you _____
9. Hemophilia or other blood disorders	☐ Yes	No ☐	If yes, relationship to you _____
10. Muscular Dystrophy	☐ Yes	No ☐	If yes, relationship to you _____
11. Cystic Fibrosis	☐ Yes	No ☐	If yes, relationship to you _____
12. Huntington's Chorea	☐ Yes	No ☐	If yes, relationship to you _____
13. Mental Retardation/Autism	☐ Yes	No ☐	If yes, relationship to you _____
13. If yes, was person tested for Fragile X?	☐ Yes	No ☐	
14. Other inherited genetic or Chromosomal Disorder	☐ Yes	No ☐	If yes, relationship to you _____

14. If yes, what?_____

15. Maternal metabolic disorder (DM, PKU, Etc)	☐ Yes	No ☐	If yes, relationship to you _____
16. Do you or the baby's father have a child with a birth defect not listed above?	☐ Yes	No ☐	If yes, relationship to you _____
17. Do you or the baby's father have a birth defect?	☐ Yes	No ☐	If yes, relationship to you _____
18. Recurrent pregnancy loss or stillbirth	☐ Yes	No ☐	If yes, relationship to you _____
19. Any NEW Medications since Last Menstrual Period	☐ Yes	No ☐	If yes, please note in "Comments" area at bottom of page
20. Any other genetic/environmental exposure to discuss?	☐ Yes	No ☐	If yes, relationship to you _____

20. If yes, what?_____

Infection History / Workplace Environment Risk

1. Live with someone with TB or TB exposed	☐ Yes	No ☐
2. You or partner has history of genital herpes	☐ Yes	No ☐
3. Rash or viral illness since Last Menstrual Period	☐ Yes	No ☐
4. History of STD (Gonorrhea, Chlamydia, Syphilis, HPV, HIV)	☐ Yes	No ☐
5. Exposed to lead, chemicals, or radiation	☐ Yes	No ☐
6. Have you had chickenpox?	☐ Yes	No ☐
7. Are your vaccinations up to date?	☐ Yes	No ☐
8. Are there cats in the home?	☐ Yes	No ☐
9. Exposed to infections at work environment (hospitals, lab work, day care, teaching)	☐ Yes	No ☐
9.		
10. Other _____	☐ Yes	No ☐
Do you have any history of High Risk Pregnancy or Pregnancy Complications such as Ectopic Pregnancy, Infertility, Gestational Diabetes, High Blood Pressure in Pregnancy, Preterm Delivery, Fetal Anomaly, Placenta Previa, Preterm Labor, C-Section, Twins, VBAC	☐ Yes	No ☐

If yes, please explain _____

If yes, please explain _____

Comments:_____