Patient name: _____ Nickname: _____ Occupation: _____ DOB: _____

Partner name: _____ Nickname: _____ Occupation: _____

Best phone number to reach you: _____

Emergency contact name/number: _____ Relationship: _____

We may have already asked you these questions at your appointment, but to be sure our record is correct, please fill out below to the best of your ability.

PREGNANCY HISTORY:

Please list all of your pregnancies below:

Birth date	Name / sex	# of weeks	Labor length	Birth weight	Vaginal or C-section?	Epidural? Other pain control?	Location of delivery / provider name	Complications? (Gestational diabetes, hypertension, preterm labor, or other issues)

How many miscarriages? _____ Terminations? _____ Any tubal (ectopic) pregnancies? _____

Any adopted or step-children? ___ Names and ages _____

MEDICAL HISTORY:

What medications were you taking prior to pregnancy? _____

What medications are you currently taking? _____

Any allergies to medications (lidocaine, penicillin, vancomycin, or other)? _____

Have you ever had surgery? Procedure and dates: _____

Do you have a personal history of any of the following:

	YES	NO		YES	NO		YES	NO
Diabetes	□	□	Thyroid disease	□	□	Breast disease or surgery	□	□
High blood pressure	□	□	Asthma	□	□	Uterine fibroids	□	□
Heart disease	□	□	Pulmonary disease / TB	□	□	Ovarian surgery	□	□
Cancer	□	□	Blood clots	□	□	Cervical procedure / LEEP	□	□
Autoimmune disorder	□	□	Bleeding disorder	□	□	Depression / anxiety	□	□
Kidney disease	□	□	Blood transfusion	□	□	ADHD	□	□
Frequent UTIs	□	□	Anesthesia complications	□	□	Psychiatric illness	□	□
Hepatitis or liver disease	□	□	Back injury or surgery	□	□	Sexual assault	□	□
Seizure disorder	□	□				Domestic violence	□	□

Abnormal Pap smears? _____ Fertility problems? _____

SOUND
OBSTETRICS & GYNECOLOGY

	YES	NO				
Tobacco use	□	□	packs/day prior to pregnancy?	_____	during pregnancy?	_____
Vaping	□	□	frequency prior to pregnancy?	_____	during pregnancy?	_____
Alcohol use	□	□	drinks/day prior to pregnancy?	_____	during pregnancy?	_____
Marijuana use	□	□	frequency prior to pregnancy?	_____	during pregnancy?	_____
Drug use	□	□	type/amount prior to pregnancy?	_____	during pregnancy?	_____

Any other medical issues? _____

Any family history of major medical problems? _____

GENETIC SCREENING:
These questions apply to you, your family members, the father of the baby and his family members:

Any family history of

	YES	NO		YES	NO
Neural tube defects (such as spina bifida)	□	□	Cystic fibrosis	□	□
Heart defects (such as tetralogy of Fallot)	□	□	Sickle cell disease or trait	□	□
Down syndrome	□	□	Thalassemia	□	□
Tay Sachs	□	□	Hemophilia	□	□
Canavan disease	□	□	Mental retardation	□	□
Muscular dystrophy	□	□	Fragile X syndrome	□	□
Huntington's chorea	□	□	Autism	□	□

	YES	NO
Are you or the father of the baby of Ashkenazi Jewish descent?	□	□
Do you have a metabolic disorder, such as PKU or insulin-dependent diabetes?	□	□
Do you, the father of the baby or your family members have a birth defect not listed above?	□	□

INFECTION RISK:

	YES	NO
Do you have cats?	□	□
Do you work closely with children (day care provider, have children in day care)?	□	□
Do you have concerns about any other workplace exposures?	□	□
Have you had the chicken pox or the vaccine?	□	□
Do you or your partner have a history of genital herpes?	□	□
Have you ever had any sexually transmitted infection, such as gonorrhea, chlamydia or syphilis?	□	□
Have you had a rash or viral illness since your last menstrual period?	□	□
Do you live with someone with tuberculosis or have you been exposed to tuberculosis?	□	□
Are you at high risk for Hepatitis B (recent immigrant, multiple sexual partners, IV drug use)?	□	□

If there is anything you feel it is important for us to know that we have not already asked, please share with us below: