



**OBSTETRICAL MEDICAL HISTORY, PAGE 2**

10. Do you have any religious or other objections to any form of medical treatment you would like to make us aware of (i.e. refusal of blood transfusion)? \_\_\_\_\_

11. Do you have any special needs for:      Hearing:  Yes  No      Vision:  Yes  No      Language:  Yes  No

**FAMILY HISTORY & GENETIC HISTORY**

1. Have either you or the baby's father had a child born with a birth defect? .....  Yes  No  
If yes, please describe: \_\_\_\_\_

2. Did either you or the baby's father have a birth defect yourselves? .....  Yes  No  
If yes, please describe: \_\_\_\_\_

3. Please describe any abnormalities that have occurred in children in your family or the baby's father's family (for example, mental retardation, birth defects, deformities, or inherited diseases like hemophilia, muscular dystrophy or cystic fibrosis). \_\_\_\_\_  
How is the affected child/person related to you? \_\_\_\_\_

4. Do either you or the baby's father have a history of pregnancy losses (miscarriages or stillborn)? .....  Yes  No  
If yes, have either of you had genetic counselling? .....  Yes  No  
If yes, have either of you had chromosomal studies? .....  Yes  No  
Where and results: \_\_\_\_\_

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

Jewish ancestry?       Yes  No      If yes, have you had Tay-Sachs screening tests? .....  Yes  No  
Date: \_\_\_\_\_ Result: \_\_\_\_\_

African-American?       Yes  No      If yes, have you had Sickle Cell screening? .....  Yes  No  
Date: \_\_\_\_\_ Result: \_\_\_\_\_

6. Please mark if anyone in your family or the baby's father's family has:

Diabetes	<input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, how is that person related to you? _____
Bleeding Disorder	<input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, how is that person related to you? _____
High Blood Pressure	<input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, how is that person related to you? _____
Cancer	<input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, how is that person related to you? _____
Hepatitis	<input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, how is that person related to you? _____
HIV	<input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, how is that person related to you? _____
Twins/multiple gestation pregnancy	<input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, how is that person related to you? _____

7. Please list any other concerns you have about birth defects or inherited disorders:  
\_\_\_\_\_  
\_\_\_\_\_

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

9. Will the father be 50 or older? .....  Yes  No

\_\_\_\_\_  
Patient Signature

\_\_\_\_\_  
Print Name

\_\_\_\_\_  
Date

Physician Notes: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_