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GENETIC HISTORY FOR OBSTETRICAL PATIENTS

Patient's Name ______________________________ Date __________________________________
DOB ______________________________________ LMP __________________________________
Age ______________________________________ Blood Type ____________________________
Father's Name (if applicable) __________________ FOB Birthdate __________________________
Mother's Race (circle all that apply)
White / Black or African American / American Indian or Alaska Native /Asian / Native Hawaiian and other Pacific Islander
Is the mother of Hispanic, Latino or Spanish origin? YES / NO
Mother's Ethnicity or Ancestry ____
Father's Race (circle all that apply)
White / Black or African American / American Indian or Alaska Native /Asian / Native Hawaiian and other Pacific Islander
Is the father of Hispanic, Latino or Spanish origin? YES / NO
Father's Ethnicity or Ancestry ____

Choose YES or NO to the questions below:

Patient's Medical History

Do you have ....

1. Diabetes Yes / No__________________
2. Hypertension Yes / No__________________
3. Seizures or epilepsy Yes / No__________________
4. Hx of treatment for cancer Yes / No__________________
5. Any birth defects, physical limitation or any known hereditary condition? Yes / No__________________
6. Any chronic medical condition? Yes / No__________________
7. History of Abnormal Pap Test? Yes / No__________________

Patient's Current Pregnancy

Have you, since becoming pregnant ....

1. Taken any medicine or drugs? Yes / No__________________
2. Had any illnesses, infections or fevers? Yes / No__________________
3. Had more than 1 glass of alcohol per day? Yes / No__________________
4. Smoked Cigarettes? Yes / No__________________
5. Eaten raw beef, fish or pork? Yes / No__________________
6. Had exposure to chemicals or radiation? Yes / No__________________

Family History

1. Are you 34 years of age or older? Yes / No__________________
2. Is the father of your baby 55 years old or older? Yes / No__________________
3. Are you and the father of the baby related? Yes / No__________________
4. Are you or the father of the baby: Hispanic, Black, Jewish, Mediterranian Yes / No__________________
5. Have you ever had a stillbirth or more than one miscarriage? Yes / No__________________

Do you or the baby's father have….

1. Any birth defects, physical limitations or chronic health problems? Yes / No__________________
2. Any previous children with birth defects, physical limitations, mental retardation or chronic health problems? Yes / No__________________
3. Any children who died? Yes / No__________________
4. Any sibling or parent with a handicap, birth defects, physical limitations, mental retardation or chronic health problems? Yes / No__________________
5. Aunts, Uncles, Cousins, nieces, nephews, grandparents or grandchildren with birth defects, a handicap or known genetic disorder? Yes / No__________________
6. A family member with mental retardation and/or learning disabilities? Yes / No__________________

Past Pregnancies

Birthdate	Name	Labor in hours	Full Term	Sex	Birth Weight Lbs/oz	Type of Delivery	Anesthesia	Place	Provider
			Y / N	M / F					
			Y / N	M / F					
			Y / N	M / F					
			Y / N	M / F					
			Y / N	M / F					

I have discussed my positive answers to the above questions with my provider.

____ ____________________________

Patient Signature Date