

Name _____ Date of Birth _____
Name of Father of Baby _____ Marital Status _____

Your age at your due date? _____ years old
Is this pregnancy the result of infertility treatments? Yes No Type _____
First day of your last menstrual period _____ Was it normal? Yes No
How often do you get your menstrual cycle? Every _____ days, lasting _____ days
Date of first positive pregnancy test _____
Were you on birth control at the time of conception? Yes No Type _____
If you've had other pregnancies, is the father of this baby the same as your other children? Yes No
What medications have you taken since your last period? _____
Do you have a cat? Yes No Who changes the litter box? _____

Your ethnicity

- | | | |
|---|--|--|
| <input type="checkbox"/> African-American | <input type="checkbox"/> Caucasian | <input type="checkbox"/> Jewish |
| <input type="checkbox"/> Asian | <input type="checkbox"/> French-Canadian | <input type="checkbox"/> Mediterranean |
| <input type="checkbox"/> Cajun | <input type="checkbox"/> Hispanic | <input type="checkbox"/> Other _____ |

Father of baby's ethnicity

- | | | |
|---|--|--|
| <input type="checkbox"/> African-American | <input type="checkbox"/> Caucasian | <input type="checkbox"/> Jewish |
| <input type="checkbox"/> Asian | <input type="checkbox"/> French-Canadian | <input type="checkbox"/> Mediterranean |
| <input type="checkbox"/> Cajun | <input type="checkbox"/> Hispanic | <input type="checkbox"/> Other _____ |

For both you & the father of the baby, is there a family or personal history of the following?

	Yes (who/what)	No		Yes (who/what)	No
Thalassemia			Muscular Dystrophy		
Sickle Cell or Trait			Cystic Fibrosis		
Congenital Heart Defect			Huntington Chorea		
Neural Tube Defect			Hemophilia		
Down's Syndrome			Mental Retardation or Autism		
Canavan Disease			Familial Dysautonomia		
Tay-Sachs			Recurrent pregnancy loss or stillbirth		
Prior child with birth defect			Other inherited, genetic or chromosomal disorders		

Details _____

Do you or your sexual partner have a history of the following?

	Yes	No	Immunized?		Yes	No	Immunized?
Hepatitis B or C				Rash or illness since last period			
Tuberculosis or exposure				History of STD			
Genital herpes				Chicken Pox			
HIV/AIDS				Syphilis			

Details _____

Are you interested in screening for birth defects & chromosomal abnormalities? Yes No Maybe
Do you want a blood test to determine if you carry the gene for Cystic Fibrosis (Caucasian & Jewish patients at highest risk) Yes No Maybe

Patient Signature _____ Date _____