

OBSTETRICAL MEDICAL HISTORY, PAGE 2

9. 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)? _____

10. 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 Yes No If yes, how is that person related to you? _____
- Bleeding Disorder Yes No If yes, how is that person related to you? _____
- High Blood Pressure Yes No If yes, how is that person related to you? _____
- Cancer Yes No If yes, how is that person related to you? _____
- Hepatitis Yes No If yes, how is that person related to you? _____
- HIV Yes 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: _____

