Name: _____
Date of Birth: _____
Date of Visit: _____

New pregnancy information sheet

What was the date of the first day of your last menstrual period? _____ Is this definite or approximate? _____

Are your cycles regular/monthly? Yes/no What was your pre-pregnancy weight? _____

How many days from the first day of menses to the first day of next menses? _____

How many times have you been pregnant? _____ What was the date of your first positive pregnancy test? _____

# of vaginal del? _____ # of Cesareans? _____ # of abortions? _____ # of miscarriages? _____ # of ectopic? _____

Pregnancies:

	Date	#wks at delivery?	length of labor?	boy or girl?	baby's weight ?	epidural (y/n)?	which hospital?	vaginal or C/S?	forceps or vacuum?	reason for C/S?
1										
2										
3										
4										
5										
6										
7										
8										
9										
10										

Please list complications from any pregnancies:

_____
_____
_____

Have you delivered any babies that did not survive? Yes/no

_____
_____

Relationship status: _____ Married _____ Single _____ Separated _____ Divorced _____ Widowed

Is the father of the baby Involved or not involved? (Please circle)

Involved partner's name _____ Involved Partner's Phone number_____

What type of work do you do? _____

Your Medical History (not family members)

Diabetes?	Yes/no	High blood pressure?	Yes/no
Heart disease?	Yes/no	Autoimmune disorders? Lupus?	Yes/no
Kidney disease/frequent UTIs?	Yes/no	Neurologic disorders/epilepsy/seizures?	Yes/no
Psychiatric disorders?	Yes/no	Depression/post-partum depression?	Yes/no
Hepatitis/Liver disease?	Yes/no	Veins in your legs that are problem?	Yes/no
Thyroid problems?	Yes/no	Any physical or sexual abuse?	Yes/no
Any blood transfusions?	Yes/no	Do you feel safe in your home?	Yes/no
History of (+) antibody screen?	Yes/no	Any lung problems? Asthma/TB	Yes/no
Seasonal allergies?	Yes/no	Any Drug or Latex allergies/Reactions?	Yes/no
Any breast problems?	Yes/no	Any Gynecologic surgeries?	Yes/no
Any operations/hospitalizations?	Yes/no	Any problems with anesthesia?	Yes/no
Any abnormal pap smears?	Yes/no	Any uterine abnormalities?	Yes/no

Any procedures done for abnormal pap smears? (like freezing, laser, or LEEP procedure)? _____

What surgeries have you had? _____

Any smoking during this pregnancy? Yes/no If yes, how much per day? _____ Or have you been able to quit? Yes/no

How much alcohol were you drinking per day before pregnancy? _____

How much alcohol are you drinking per day since knowing you were pregnant? _____

Have you used any drugs since your last period? Yes/no If yes, please list type and amount: _____

Any infertility w/this pregnancy or treatment? Yes/no _____

What medical problems run in your family? (Diabetes, High Blood Pressure, etc.) _____

_____

Genetic Screening

Will you be 35 or older at the time the baby is delivered? Yes/no

Do any of these things run in your family or the baby's fathers' family?

Down Syndrome? Yes/no

Developmental Disability or autism? Yes/no

If yes, was that person checked for Fragile X? Yes/no

Neural tube defects? (spina bifida/anencephaly) Yes/no

Anyone in the family born with heart defects? Yes/no

If yes, did they require surgery? Yes/no

Any Thalassemia, Tay sachs, Canavan Disease, Sickle Cell Disease/ Sickle Cell Trait, Hemophilia/other blood disorders, Muscular Dystrophy, Cystic Fibrosis, Huntington's Chorea, or any other inherited genetic disorders not mentioned?

Yes/no

If yes, please list_____

Any Italian, Greek, Mediterranean, African, Asian, Jewish, Cajun or French-Canadian background? (Please circle)

Any metabolic disorders? Yes/no

If yes, please list:_____

Have you or your partner had a child with birth defects not listed above? Yes/no

If yes, please list:_____

Have you had recurrent miscarriages or a stillbirth? Yes/no

Have you taken any medications, supplements, vitamins, herbs or over the counter medications since your last menstrual period? Yes/no

If yes, please list: _____

What is your ethnicity/ancestry? _____

What is the baby's father's ethnicity/ancestry? _____

Have you or the baby's father had any genetic screening done? Yes/no

If yes, which tests? _____

Infection History

Are you living with someone that has Tuberculosis (TB) or have you been exposed to TB? Yes/no

Do you or your partner have a history of Genital Herpes (HSV-2)? Yes/no

Have you had any rashes or viral illnesses since your last menstrual period? Yes/no

Do you have any history of having had any of the following?
Gonorrhea, Chlamydia, Human Papilloma Virus (HPV), Syphilis or HIV? (Please circle)

Do you have cats as pets? Yes/no

If yes, are you changing the litter box? Yes/no