Name: _____
Birth Date: _____
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?_____

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

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

Father of the baby's name_____

Phone number_____

Involved or not involved? (please circle)

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(cyrotx), 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, ect.) _____

_____

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?

Thalassemia? Yes/no

Any Italian, Greek, Mediterranean or Asian background? (Please circle)

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

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

Did they require surgery? Yes/no

Down Syndrome? Yes/no

Tay sachs? Yes/no

Any Jewish, Cajun or French Canadian background? (Please circle)

Canavan Disease? Yes/no

Sickle Cell Diease or Sickle Cell Trait? Yes/no

Any African background? Yes/no

Hemophilia or other blood disorders? Yes/no

Muscular dystrophy? Yes/no

Cystic fibrosis? Yes/no

Huntington's Chorea? Yes/no

Mental retardation or autism? Yes/no

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

Any other inherited genetic disorders not mentioned above? Yes/no

If yes, please list:_____

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: _____

Have you smoked, drank alcohol or used any drugs since your last menstrual period? Yes/no

If yes, please list:_____

What is your ethnicity/ancestry?_____

The baby's fathers'? _____

Do you have any Jewish ancestry? Yes/no

Does the baby's father? Yes/no

If yes, 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