Obstetrical History (Supplement)

(To Be Completed if Currently Pregnant)

Patient Name _____

What was the **FIRST** day of your last menstrual period _____ Is this date definite ☐ Yes ☐ No

Cycles regular ☐ Yes ☐ No Cycle length (average = 28 days) _____ Date of first positive pregnancy test _____

Conception (check one) ____normal estimated date of conception _____ IVF / IUI due date: _____

What was your weight just before becoming pregnant? _____ What is your height _____

When was your last pap smear _____ Performed by whom _____ Was it normal ☐ Yes ☐ No

INFECTION SCREENING

(Please circle your response to each question)

1. Do you live with someone who might have tuberculosis	Yes	No	
2. Do you or your partner have a history of genital herpes	Yes	No	
3. Have you had a skin rash or viral illness since your last period	Yes	No	
4. Have you ever tested positive for hepatitis B or C	Yes	No	
5. Have you ever had gonorrhea, syphilis, Chlamydia or venereal warts **(if yes circle all that apply)**	Yes	No	
6. Do you or your partner have a history of a blood transfusion	Yes	No	
7. Do you or your partner have a history of IV drug use	Yes	No	
8. Are you HIV positive	Yes	No	
9. Do you have HPV, genital warts or cervical cancer **(if yes circle all that apply)**	Yes	No	
10. Have you ever had chickenpox	Yes	No	

FAMILY GENETIC SCREENING

(If you, the father, parents, siblings, or other children, currently have or have had any of the conditions listed below, please circle yes)

1. Will you be 35 or older when you deliver	Yes	No	
2. History of stillbirth or 2 or more miscarriages	Yes	No	
3. History of Thalassemia or hemoglobin disorder	Yes	No	
4. History of Tay-Sachs Disease	Yes	No	
5. History of neural tube defect (Spina Bifida)	Yes	No	
6. History of congenital heart defect	Yes	No	
7. History of Down Syndrome	Yes	No	
8. History of Hemophilia	Yes	No	
9. History of Muscular Dystrophy	Yes	No	
10. History of Cystic Fibrosis	Yes	No	
11. If you answered yes to # 10 has Cystic Fibrosis carrier testing been performed	Yes	No	NA
12. History of Huntington's Disease (Huntington's Chorea)	Yes	No	
13. History of mental retardation	Yes	No	
14. If you answered yes to # 13, has testing for Fragile X chromosome been performed	Yes	No	NA
15. History of any inheritable genetic syndrome or any birth defects	Yes	No	
16. History of Maternal PKU or other Metabolic Syndrome	Yes	No	
17. Is either parent adopted	Yes	No	
18. Is the mother or father of the baby Ashkenazi Jewish or Cajun	Yes	No	
19. If you answered yes to #18, has any genetic testing been performed	Yes	No	NA
20. Is the mother or father of the baby African- American	Yes	No	
21. History of Sickle Cell Anemia	Yes	No	
22. Has any Sickle Cell Anemia testing been performed	Yes	No	
23. Is the mother or father of the baby Mediterranean	Yes	No	

REPRODUCTIVE HISTORY

(Please circle your response to each question)

What was your most recent method of birth control _____

Did your mother receive DES (diethylstilbestrol) when she was pregnant with you	Yes	No	Unsure
Do you have uterine abnormalities (fibroids, uterine septum, double uterus)	Yes	No	
Have you tried to get pregnant for 12 months or longer without success	Yes	No	
Have you had a previous pregnancy	Yes	No	
If you answered yes to question # 4, have you had any of the following:			
Gestational diabetes	Yes	No	
Preeclampsia	Yes	No	
Elective abortion	Yes	No	
Ectopic pregnancy	Yes	No	
Pregnancy ending in miscarriage from 14 – 20 weeks	Yes	No	
Stillbirth after 20 weeks	Yes	No	
Any infant weighing less than 5.5 pounds at birth	Yes	No	
Any infant weighting more than 9 pounds at birth	Yes	No	
Any birth by cesarean section	Yes	No	
Any infant who died prior to their first birthday	Yes	No	