Lincoln Park OB/GYN

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OB Genetic History

Office Use Only

Patient # ________________ Date _________

Name ____ DOB ______________________

Note: This record is confidential. Information will not be released to anyone without your authorization.

Today's Date ______________________ Last Menstrual Period ______________________

Current Pregnancy

If you answer yes to any of the following questions, please explain on the space provided.

Have you taken any medication (prescription or over the counter) since becoming pregnant or since your last period? ❍ Yes ❍ No

____

Have you had any illness or infection during this pregnancy? ❍ Yes ❍ No

____

Have you had a fever over 101° or taken saunas or hot whirlpool baths during this pregnancy? ❍ Yes ❍ No

____

Have you had x-rays or surgery since becoming pregnant? ❍ Yes ❍ No

____

Have you been exposed to anesthetic gases,lead, or radiation in your occupation? ❍ Yes ❍ No

____

Have you consumed more than one glass of alcohol per week during this pregnancy? ❍ Yes ❍ No

____

Did you become pregnant while using birth control pills? ❍ Yes ❍ No

____

Patient Medical History

If you answer yes to any of the following questions, please explain on the space provided.

Do you have diabetes? ❍ Yes ❍ No

____

Do you have seizures or epilepsy? ❍ Yes ❍ No

____

Do you have kidney disease? ❍ Yes ❍ No

____

Do you or the baby's father have a history of treatment for cancer? ❍ Yes ❍ No

____

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Name ______________________ Patient # ____________ Date ________

Patient Medical History (Continued)

Will you be 35 years old or older at the time of delivery? ❍ Yes ❍ No

Will the baby's father be 35 years old or older at the time of delivery? ❍ Yes ❍ No

Is there any chance that you and the father could be blood relatives? ❍ Yes ❍ No

Are you or the father of Jewish, African American or Mediterranean descent? ❍ Yes ❍ No

Have you ever had a still birth? ❍ Yes ❍ No

Have you ever had a miscarriage? ❍ Yes ❍ No

Have you or the baby's father had birth defects, handicaps, or other conditions that could be hereditary? ❍ Yes ❍ No

Have you had other children with birth defects, handicaps or genetic diseases? ❍ Yes ❍ No

Do you have siblings or parents with birth defects, handicaps, or genetic diseases? ❍ Yes ❍ No

Do you have aunts, uncles, cousins, nieces, nephews, grandparents or grandchildren with birth defects, handicaps, or genetic diseases? ❍ Yes ❍ No

Do you know of any family member with mental retardation (even mild) or learning disabilities? ❍ Yes ❍ No

Do you have children that have died other than in accidents? ❍ Yes ❍ No

Do you have any other medical conditions? ❍ Yes ❍ No

Birth Defect and Genetic Disease Examples

Anencephaly
Blindness or Eye Conditions
Bone Disorders
Cerebral Palsy
Chromosome Abnormality
Cleft Lip or Cleft Palate
Congenital Heart Defect
Cystic Fibrosis
Deafness
Down Syndrome (Mongolism)
Epilepsy
Genital Abnormalities
Hemophilia (Bleeding Tendency)
Hydrocephalus (Water on the Brain)
Infertility
Kidney Disease
Limb Defects
Malformations
Mental Illness
Mental Retardation
Muscular Dystrophy
Neurofibromatosis
Neurologic or Degenerative Disorder
Short Stature (Under 5 Feet Tall)
Skin Disease
Sickle Cell Anemia
Spina Bifida (Open Spine)
Urinary Tract Abnormality