Date:________________________________

Name:____Date of birth:_________________________

Referring M.D.:____SSN:________________________________

Why did your Doctor refer you today? ____

____

Please describe any health problem or symptoms that you are having at this time:_________________

____

Due Date:_____________________First Day of Last Menstrual Period: ___________________________

(Please circle if Dated by Ultrasound or Last Menstrual Period)

Have you ever had an Ultrasound at D.P.A. in a prior pregnancy (please state the year)? ______________

Are you allergic to any medications?____

Latex Allergies? ___________Tape Allergies?_______________Iodine/Shellfish Allergies?______________

PREGNANCY HISTORY: (Include miscarriages, terminations, and/or ectopic pregnancies)

Date Month/Year	Gestational Age (Weeks)	Birth Weight	Sex M/F	Type of Delivery: Vaginal/ C-Section	Preterm Labor: Yes/ No	Comments/ Complications

GYNECOLOGICAL HISTORY:

Date of last Pap smear? ____

Have you ever had an Abnormal Pap Smear? ____

If yes, when? ____

Any Procedures on your Cervix? (Biopsy, LEEP, CRYO Surgery, Colposcopy) _____________________

____

Any Uterine abnormality? Yes No Fibroids? Yes No Bicornuate Uterus? Yes No

Any Infertility problems?____

Is this pregnancy: IVF (Invitro Fertilization) IUI (Intrauterine Insemination)

MEDICAL HISTORY: Please mark any condition that you have been treated for in the past or are currently being treated for.

	YES	NO		YES	NO
Asthma / TB / Pulmonary			High Blood Pressure		
Cancer			Kidney Disease		
Depression/ Post Partum Depression/ Anxiety			Hepatitis B/C		
Diabetes			Von Willebrand's Disease or other Bleeding disorders		
Eating Disorder			Blood Clotting Disorders		
Anemia			Sexually Transmitted Diseases		
Thyroid Disorder			HIV/AIDS		
Arthritis or Lupus			Bowel Disease		
Epilepsy/ Neurologic			Heart Disease		
History of Blood Transfusion			D (Rh) Sensitized		
PKU					

Have you ever had any kind of Surgery (Please state year(s) procedure was performed)?____

Do you or any family member have a history of problems with anesthesia?
If yes, please explain: ____

PERSONAL HEALTH HISTORY

Do you have any religious objections to any form of medical treatment (refusal of blood transfusion)?
If yes, please explain: ____

FAMILY HISTORY & GENETIC SCREENING

Have you or has the father of the baby had a child born with a birth defect? (Spina Bifida, Hole in the heart, Down Syndrome, Cleft lip) If yes, please describe: ____

Did you or the father of the baby have a birth defect? If yes, please describe: __________________________

Please describe any abnormalities that have occurred in children of your family or the father of the baby's family (Mental retardation, birth defects, deformities, or inherited diseases such as hemophilia, muscular dystrophy, or cystic fibrosis). How is this child/person related to you? ____________________________

Is the father of the baby over the age of 50? Yes No

Do you or does the father of the baby have a history of pregnancy loses (miscarriages or stillbirths)? ______________

GENETIC SCREENING: (Includes patient, father of baby, or anyone in either family)

	YES	NO		YES	NO
1. patient's age >35 years as of estimated date of delivery			7. Hemophilia or other Blood Disorders.		
2. Thalassemia (Italian, Greek, Mediterranean, or Asian background) MCV < 80			8. Muscular Dystrophy.		
3. Neural Tube Defect (Meningomyelocele, Spina Bifida, or Anencephaly)			9. Cystic Fibrosis		
4. Congenital Heart Defect			10. Down Syndrome		
5. Tay-Sachs (Jewish, Cajun, French Canadian)			11. Mental Retardation/ Autism		
6. Sickle Cell Disease or Trait (African)			12. Other Inherited Genetic or Chromosomal Disorder		

EXPOSURES AFFECTING HEALTH:

Do you smoke cigarettes? If yes, How much per day? ______________________________
Do you drink alcoholic beverages now or did you before you became pregnant? If yes, how often? ________
____

Have you had any X-rays or any chemical exposure (harsh chemicals at work) since pregnant?____

Please list any medications being taken in this pregnancy (even before knowing you were pregnant) ________
____
____

Please list any illicit or recreational drugs used since pregnant. (Marijuana, Cocaine) __________________
____

Are you on a restricted diet?
If yes, please explain: ____

PSYCHOSOCIAL SCREENING:

Do you have any problems (job, transportation, etc.) that prevent you from keeping your health care appointments? ____

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FOR OFFICE USE ONLY:
G: _________P:__________PRETERM:_______SAB:_______TAB:_______LIVING:_________