

METROPOLITAN OB/GYN GENETIC AND FAMILY HISTORY

Patient Name _____ DOB _____ Date _____

Attitude towards Pregnancy: Planned Unplanned Plan to parent/keep Adoption

Drug use: (Past/Current):

Tobacco Yes No Prepregnancy amt. _____ Pregnancy amt. _____ Yrs. total use _____

Alcohol Yes No Prepregnancy amt. _____ Pregnancy amt. _____ Yrs. total use _____

Caffeine Yes No Prepregnancy amt. _____ Pregnancy amt. _____ Yrs. total use _____

Street Drugs Yes No Prepregnancy amt. _____ Pregnancy amt. _____ Yrs. total use _____

Herbal Supplements Current/Past _____

Have you or any members of your family been born with or affected by any known genetic problem, retardation, birth defects, or major medical problems?

	<i>Patient</i>	<i>Father of Baby</i>	<i>Family</i>
1. Patient's age • 35 yrs or over	<input type="checkbox"/>		
Father of baby • 50 years or over		<input type="checkbox"/>	
2. Italian, Greek Mediterranean or Asian background (Thalassemia):.....	<input type="checkbox"/>	<input type="checkbox"/>	
3. Ashkenazi, Jewish, Cajun, Fr. Canadian background (Tay Sachs)?	<input type="checkbox"/>	<input type="checkbox"/>	
4. African or Latin American background (sickle cell)?	<input type="checkbox"/>	<input type="checkbox"/>	
5. Down syndrome or other chromosomal problem?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6. Hemophilia or other bleeding disorder?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7. Muscular dystrophy or anyone in family in a wheelchair?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8. Cystic fibrosis or any other metabolic disorder?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9. Huntington's Chorea?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10. Mental retardation or autism?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
11. Maternal medical problems? (diabetes, lupus, epilepsy, PKU, etc.)	<input type="checkbox"/>		
12. Other inherited genetic or chromosomal disorder?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
13. Child with birth defects not listed above?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
14. Patient or Father of Baby with birth defect?	<input type="checkbox"/>	<input type="checkbox"/>	
15. More than 3 first trimester spontaneous abortions or a stillbirth?	<input type="checkbox"/>		<input type="checkbox"/>

Infection History

	Yes	No
Do you live with someone that has or ever been exposed to TB?	<input type="checkbox"/>	<input type="checkbox"/>
Have you ever had chicken pox?	<input type="checkbox"/>	<input type="checkbox"/>
Have you had a rash or any viral illness since LMP?	<input type="checkbox"/>	<input type="checkbox"/>
Have you ever been diagnosed with an STD?	<input type="checkbox"/>	<input type="checkbox"/>
Do you have cats in your home?	<input type="checkbox"/>	<input type="checkbox"/>
Do you have close contact with young children on a regular basis?	<input type="checkbox"/>	<input type="checkbox"/>