Patient Name_____ **Account Number**_____

GENETIC HISTORY FORM OBSTETRICAL PATIENTS

The following information is very important to your health. Please take time to fully and completely fill out this important information. We are counting on you.

Medical History

Yes	No	Do you . . .	
□	□	1. Have Diabetes?	_____
□	□	2. Have seizures or epilepsy?	_____
□	□	3. Have Kidney Disease?	_____
□	□	4. Or your husband/boyfriend have a history of treatment for cancer?	_____
□	□	5. Have any dermatological disorders, including, skin, moles, acne, light or dark patches of skin?	_____
□	□	6. Have rheumatoid arthritis or systemic lupus erythematosis?	_____
□	□	7. Have a history of being on a special diet as a baby or small child due to PKU or another condition? (You may need to ask your parents about this.)	_____
□	□	8. Have any other medical condition not mentioned?	_____
□	□	9. Know the results of your routine prenatal blood test for rubella (German measles) susceptibility and if yes, check below: □ Immune □ Susceptible (not immune)	_____

Family History

□	□	10. Are you 34 years old or older?	_____
□	□	11. Is your husband/boyfriend 55 years or older?	_____
□	□	12. Are you and your husband/boyfriend of □ Jewish □ Black □ Mediterranean descent?	_____
□	□	13. Are you and your husband/boyfriend blood relatives (e.g. cousins)?	_____
□	□	14. Have you had a stillbirth or more than one miscarriage?	_____
□	□	15. Have any birth defects, handicapping condition or disorder that might be hereditary?	_____
□	□	16. Have any previous children with birth defects, handicaps, or genetic disease?	_____
□	□	17. Have any children who died (other than in accidents)?	_____
□	□	18. Have a brother, sister, or parent with a handicap, birth defects or genetic disease?	_____
□	□	19. Have uncles, cousins, nieces, nephews, grandparents, or grandchildren with birth defects or genetic disease?	_____
□	□	20. Know of any family member with mental retardation (even mild) or learning disabilities?	_____

Some examples of birth defects and genetic diseases that might be in your family:
Please check any of the following that might be in your family:

□ Anencephaly (open skull)
□ Blindness or eye problem
□ Bone disorder
□ Cerebral palsy
□ Chromosome abnormality
□ Cleft lip/palate
□ Cystic fibrosis
□ Deafness
□ Down's syndrome (mongolism)
□ Epilepsy or seizures
□ Heart defect
□ Hemophilia (bleeding tendency)
□ Hydrocephalus (water on the brain)
□ Infertility
□ Kidney disease
□ Limb defects
□ Malformation of birth defects
□ Mental Illness
□ Mental retardation
□ Muscular dystrophy
□ Neurofibromatosis
□ Neurologic or degenerative disorder
□ Short stature (under 5ft.)
□ Sickle cell anemia
□ Skeletal problems (like easy broken bones or curvature of the spine)
□ Skin disease (including dark or light patches)
□ Spina Bifida (open spine)
□ Tay- Sachs/Gaucher Disease
□ Urinary tract abnormalities
□ Other

Environmental Exposure History

Yes	No	Have you. . .
□	□	21. Taken any prescription drugs or over-the-counter medications since becoming pregnant or since your last period?_____ _____
□	□	22. Taken any of the following since becoming pregnant or since your last period?

□ Accutane or other dermatologic or acne medications
□ Antibiotics such as Tetracycline or Streptomycin
□ Anticoagulants (blood thinners to prevent blood clots)
□ Antithyroid drugs
□ Birth control pills
□ Chemotherapeutic drugs (anti-cancer)
□ Diet pills
□ Female hormones
□ Male hormones
□ Medications or epilepsy(seizure)
□ Multi-vitamins
□ Steroids
□ Tranquilizers
□ Vitamin A supplements
□ Other high dose vitamins

□	□	23. Had any illness or infection during pregnancy?
□	□	24. Had fever over 101, or taken saunas or hot whirlpool baths during pregnancy?
□	□	25. Had x-rays or surgery since becoming pregnant?
□	□	26. Been exposed to anesthetic gases lead, or other heavy metals or radiation in your condition?
□	□	27. Been exposed to pesticides or potentially toxic chemicals at home or elsewhere?
□	□	28. Drink: □ Well water □ City water □ Bottled water
□	□	29. Drink more than one glass of alcohol per week (including beer)?
□	□	30. Have a household cat?
□	□	31. Clean a cat litter box?
□	□	32. Eat raw or very rare meat?
□	□	33. Smoke more than ½ pack of cigarettes per day?
□	□	34. Use any other drugs or medications not previously listed?

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my health. It is my responsibility to inform the doctor's office of any changes in my medical status. I also authorize the healthcare staff to perform the necessary services I may need.

_____ _____ _____
Patient Signature Print Name Date

_____ _____
Physician Signature Date