



Medical Record Number:

Patient name

Label

The information on this sheet is confidential

Communications

Preferred language:	How would you rate your spoken English? <input type="checkbox"/> Native <input type="checkbox"/> Fluent <input type="checkbox"/> Basic <input type="checkbox"/> Very Little
If you have difficulty with English, do you want us to discuss your care with anybody on your behalf? <input type="checkbox"/> Yes <input type="checkbox"/> No	
If "Yes", please state name, ph number, and relationship to you:	
Name of partner or 2nd parent of the baby:	
How is your partner or 2nd parent of the baby involved? <input type="checkbox"/> I live with them <input type="checkbox"/> Very involved <input type="checkbox"/> Somewhat involved <input type="checkbox"/> Involved very little <input type="checkbox"/> Not involved at all	
Do you give permission to share information with your partner or 2nd parent of the baby? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not sure	What is your partner or 2nd parent of the baby's phone number?
Do you have children living at home? <input type="checkbox"/> Yes <input type="checkbox"/> No	

If "Yes", please list the names and ages of the children.

Name				
Age				

Psycho-Social Information

Do you have a history of clinical depression or anxiety requiring treatment?	Y	N	Have you ever been sexually, physically, or emotionally abused?	Y	N
Has your current partner ever hit, kicked, pushed, or slapped you?	Y	N	Do you feel threatened at home? If "Yes", please explain	Y	N
Do you have any beliefs that restrict the use of blood products?	Y	N	Do you work? <input type="checkbox"/> Yes <input type="checkbox"/> No If "Yes", <input type="checkbox"/> Full time <input type="checkbox"/> Part time <input type="checkbox"/> From home		
If you work, what type of work do you do?			If you work, please list your employer.		
Do you go to school? <input type="checkbox"/> Yes <input type="checkbox"/> No If "Yes", may select several <input type="checkbox"/> Full time <input type="checkbox"/> Part time <input type="checkbox"/> Work from home <input type="checkbox"/> Work on site					

Pregnancy

Are you carrying twins or multiples?		Y	N
Is this pregnancy a result of IVF (in vitro fertilization)?		Y	N
If IVF pregnancy: What was the transfer date? _____ Was the egg from a donor? <input type="checkbox"/> Yes <input type="checkbox"/> No Did you have any genetic screening/testing for the embryo(s)? <input type="checkbox"/> Yes <input type="checkbox"/> No			
Additional IVF Comments:			
Have you ever been pregnant before? <input type="checkbox"/> Yes <input type="checkbox"/> No			
In previous pregnancies have you ever experienced any of the following:			
<input type="checkbox"/> Ectopic Pregnancy		<input type="checkbox"/> PPH (postpartum hemorrhage)	
<input type="checkbox"/> Gestational Diabetes		<input type="checkbox"/> Developed postpartum depression	
<input type="checkbox"/> Elevated blood pressure during pregnancy		<input type="checkbox"/> Shoulder Dystocia (baby's shoulder gets stuck during birth)	
<input type="checkbox"/> Delivered a baby before 37 weeks gestation		<input type="checkbox"/> Delivered a baby with a heart defect or other congenital problem	
<input type="checkbox"/> Cesarean Section			
<input type="checkbox"/> Severe Lacerations (3rd or 4th degree)			
Add any additional comments or complications:		<input type="checkbox"/> No significant complications	

Genetics/Ancestry

Do you have Ashkenazi Jewish ancestry? <input type="checkbox"/> Yes <input type="checkbox"/> No
If "Yes", were tested for conditions like Tay-Sachs, Gaucher's, Canavan Disease, Familial Dysautonomia, etc? <input type="checkbox"/> Yes <input type="checkbox"/> No
Do you have African ancestry? <input type="checkbox"/> Yes <input type="checkbox"/> No If "Yes", have you been tested for Sickle Cell trait? <input type="checkbox"/> Yes <input type="checkbox"/> No



Medical Record Number:

Patient name

Label

The information on this sheet is confidential

Do you have Mediterranean or Asian ancestry? <input type="checkbox"/> Yes <input type="checkbox"/> No	If "Yes", have you been tested for Thalassemia? <input type="checkbox"/> Yes <input type="checkbox"/> No
Have you or your partner had any carrier screening for autosomal recessive diseases or other types of genetic testing? <input type="checkbox"/> Yes <input type="checkbox"/> No	If "Yes", what testing have you had?

Do you or the father have personal or family history of any of the following:

<input type="checkbox"/> Congenital Heart Defect	<input type="checkbox"/> Sickle Cell Disease or Trait
<input type="checkbox"/> Autism	<input type="checkbox"/> Hemophilia or other blood disorders
<input type="checkbox"/> Cystic Fibrosis	<input type="checkbox"/> Two or more miscarriages or stillbirths
<input type="checkbox"/> Muscular Dystrophy or other physical disabilities	<input type="checkbox"/> Unexplained infant or childhood deaths
<input type="checkbox"/> Tay-Sachs, Canavan Disease, or Familial Dysautonomia	
<input type="checkbox"/> Neural Tube Defect (Meningomyelocele, Spina Bifida, Anencephaly)	
<input type="checkbox"/> Chromosome disorders (Down Syndrome, Mongolism, Trisomy 13 or 18, translocation)	
<input type="checkbox"/> Other inherited genetic disease, chromosomal disorder, birth defects, or cardiac defects	
<input type="checkbox"/> No significant history	Please add any additional genetic related comments:

Medications/Exposure Since Last Menstrual Period
Since your last menstrual period have you:

<input type="checkbox"/> Taken supplements, vitamins, herbs, or over-the-counter-drugs
<input type="checkbox"/> Taken lithium, valium, or anticonvulsants
<input type="checkbox"/> Taken accutane, iodides to treat hyperthyroidism, anticoagulants, or anticancer drugs
<input type="checkbox"/> Taken illicit/recreational drugs, alcohol, or cigarettes/nicotine
<input type="checkbox"/> Been exposed to chemicals or other dangers at work or home (e.g. paints, polishes, pesticides, leads, cats, hot baths, douching, x-rays, lifting)
<input type="checkbox"/> None

Please add additional details about your answer(s) above:

Infection Assessment

Have you had Chickenpox/Shingles before or been vaccinated? <input type="checkbox"/> Yes <input type="checkbox"/> No	if "Yes", when?
Have you received the Influenza vaccine this year? <input type="checkbox"/> Yes <input type="checkbox"/> No	if "Yes", when?
Have you received the Tdap vaccine before? <input type="checkbox"/> Yes <input type="checkbox"/> No	if "Yes", when?
Have you been exposed to TB (Tuberculosis)? <input type="checkbox"/> Yes <input type="checkbox"/> No	if "Yes", please explain.
Have you been exposed to a STI (Sexually Transmitted Infection)? (Hepatitis, HIV, Syphilis, Gonorrhea, Chlamydia) <input type="checkbox"/> Yes <input type="checkbox"/> No	If "Yes", please explain.
Have you or your partner ever had oral herpes (cold sores) or genital herpes outbreaks? <input type="checkbox"/> Yes <input type="checkbox"/> No	If "Yes", please explain.
Have you recently been around a child with a rash? <input type="checkbox"/> Yes <input type="checkbox"/> No	if "Yes", please describe.
Have you had a blood transfusion in the past? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Did you, your partner, or anyone you live with travel during the last 6 months? <input type="checkbox"/> Yes <input type="checkbox"/> No	if "Yes", please describe
Do you, your partner, or anyone you live with have travel plans during this pregnancy? <input type="checkbox"/> Yes <input type="checkbox"/> No	if "Yes", please describe

Pap Test Information

Have you ever had an abnormal Pap test result? <input type="checkbox"/> Yes <input type="checkbox"/> No
If "Yes", please explain.
What is the date of your last Pap test?
What was the results of your last Pap test? <input type="checkbox"/> Normal <input type="checkbox"/> Abnormal <input type="checkbox"/> Not sure