

Gulf Coast OB/GYN, P.A.

Date _____ Age _____

Name _____ Date of Birth _____

Address _____ City & State _____ Zipcode _____

Phone # _____ Emergency # and name _____

Race: W B H Other _____ Marital Status: S M D Sep W

Insurance _____ Religion _____

Baby's father's name and age _____

Past/Present Medical Problems (example; diabetes, high blood pressure, kidney, etc.) _____

List any surgeries you have had _____

List all medications (prescription and over the counter) you are taking _____

Are you allergic to any medications? If yes, list them _____

Have you been pregnant before? YES NO If yes, please answer the following;

Date of delivery	Sex	Weight	Type of delivery	Problem(s)

GYNECOLOGICAL HISTORY

Last Menstrual Period _____ Any abnormal pap test? YES NO

If yes, when and where test was performed _____

Any previous sexually transmitted disease(s)? _____

Age you started your period? _____ Are your cycles regular? _____ # of days you bleed _____

SOCIAL HISTORY

Do you smoke _____ Do you drink alcohol _____ Do you use drugs _____

FAMILY HISTORY

Any family female related cancers? _____

Any breast cancer in your family? _____

If medically necessary, would you accept a blood transfusion? YES NO

GENETIC SCREENING QUESTIONNAIRE

These questions pertain to the patient, baby's father or anyone else in either family.

Name of Patient _____

Record # _____

1. How many times have you been pregnant (including this pregnancy)? _____
2. How many live-born babies have you had? _____
3. Are all of your children still living? YES or NO

History of Present Illness

1. Since your last period do you have any complaints regarding this pregnancy? YES or NO
2. Since your last period have you had alcohol, smoked tobacco or used substances (street drugs)? YES or NO
3. Are you or the baby's father of Jewish ancestry? YES or NO
4. Are there any cats in the home? YES or NO indoor or outdoor?
5. Do you have close contact with children on a regular basis? YES or NO
6. Have you had Chicken Pox? YES or NO
7. Have you been a victim of domestic violence? YES or NO

Maternal History

1. How old will you be when you have your baby? _____
2. Have you taken any medications since your last period, other than prenatal vitamins? YES or NO
3. Have you had any other genetic or environmental exposure to discuss? YES or NO
4. Are you or the baby's father of Italian, Greek, Mediterranean or Asian background? YES or NO
5. Do you have Neural tube defect (meningomyelocele, spina bifida, anencephaly)? YES or NO
6. Do you have a congenital heart disease? YES or NO
7. Do you have Down Syndrome or Mongolism? YES or NO
8. Have you had Tay-Sachs (Jewish, French Canadian)? YES or NO
9. Have you had Canavan's Disease? YES or NO

10. Do you or the baby's father have a history of Sickle Cell Disease or have an African trait? YES or NO
11. Do you have hemophilia or other blood disorders? YES or NO
12. Do you have Muscular Dystrophy? YES or NO
13. Do you have Cystic Fibrosis? YES or NO
14. Do you have Huntington's Chorea? YES or NO
15. Is Mental Retardation/Autism in your family or the baby's father's family? YES or NO
16. Are there other Inherited Genetic or Chromosomal Disorders in either family? YES or NO
17. Do you have a Metabolic Disorder (diabetes, Phenylketonuria, etc.)? YES or NO
18. Do you or the baby's father have a birth defect not listed above? YES or NO
19. Do you or the baby's father have a birth defect? YES or NO
20. Have you had a miscarriage? YES or NO Have you had a Stillborn baby? YES or NO

Infection History

1. Do you live with someone with Tuberculosis or have you be exposed to it? YES or NO
2. Do you or your partner have a history of genital herpes? YES or NO
3. Have you had a rash or viral illness since your last period? YES or NO
4. Have you or your partner had a history of Gonorrhea, Chlamydia, HPV, Syphilis, HIV? YES or NO
5. Have you had any other infectious history? YES or NO

Patient's signature

Date