Date: ________________ **GULF COAST OB/GYN** MRN: _________________

NEW OB PATIENT PMH

Last Name: ________________________________ First: _________________________________ MI: _______ Age: ________

DOB: _________________ SSN: _________________________ Marital Status: ___Single ___Married ___Divorced ___Widowed

Ethnicity: ___Not Hispanic ___Hispanic Race: _____________________________ Language: ______________________________

Address: ____ APT# ____________

City: _____________________________ State: ________ Zip: _________________ County: _____________________________

Phone: ______________________________ Emergency # and Name: ____

Insurance: ____ Religion: _________________________________

Baby's Father's Name and Age: ____

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

____

Past Surgeries: ____

List all Medications (prescription and over the counter) you are taking ____

____

List all Medications You are Allergic to: ____

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 Smears? 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 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 Intellectual Disability/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

21. 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