



Obstetrical Screening

Date: __/__/__

Name: _____

Age: _____

Date of birth: __/__/__

Last menses: __/__/__

Pregnancy History:

Year	Delivery(vaginal, C/S, Miscarriage, termination, ectopic)	Gender	Weight	Hospital	Complications

Have you undergone infertility treatment? (If yes, please describe):

Race/ethnicity:

- | | | |
|---------------------------------------|---|---|
| <input type="radio"/> White | <input type="radio"/> Asian-East Indian | <input type="radio"/> Hispanic |
| <input type="radio"/> Black | <input type="radio"/> Filipino | <input type="radio"/> Other Southeast Asian |
| <input type="radio"/> Chinese | <input type="radio"/> Japanese | <input type="radio"/> Other |
| <input type="radio"/> Native American | <input type="radio"/> Middle Eastern | <input type="radio"/> Unknown |

Genetic and Medical History:

Have you, your partner or anyone in either family (blood relatives) had any of the following?
 (This questionnaire will provide us with information about your genetic and medical background.)

- | | |
|---|---|
| <ul style="list-style-type: none"> <input type="radio"/> Sickle cell anemia <input type="radio"/> Thalassemia <input type="radio"/> Bleeding disorders (i.e. hemophilia) <input type="radio"/> Tay Sachs disease <input type="radio"/> Cystic fibrosis <input type="radio"/> Muscular dystrophy (or other muscle wasting diseases) <input type="radio"/> Spina bifida (openings in the spine) <input type="radio"/> Hydrocephalus ("water on the brain") <input type="radio"/> Mental disabilities <input type="radio"/> Kidney disease <input type="radio"/> Heart malformations <input type="radio"/> Down's syndrome <input type="radio"/> Unexplained infant or childhood deaths <input type="radio"/> Other birth defects or disorders(describe below) | <ul style="list-style-type: none"> <input type="radio"/> Other chromosome disorders (describe below) <input type="radio"/> Enzyme or metabolic diseases (ex G6PD def) <input type="radio"/> Malformations of the brain <input type="radio"/> Malformations of other organs (describe below) <input type="radio"/> Diabetes <input type="radio"/> Autoimmune disorders (i.e. lupus, rheumatoid arthritis) <input type="radio"/> High blood pressure <input type="radio"/> Seizures <input type="radio"/> Postpartum depression <input type="radio"/> Hypothyroid disease |
|---|---|

Are you taking any of the following?

- | | |
|---|--|
| <ul style="list-style-type: none"> <input type="radio"/> Lithium <input type="radio"/> Valium <input type="radio"/> Accutane | <ul style="list-style-type: none"> <input type="radio"/> Anti-seizures medications <input type="radio"/> Iodine to treat hyperthyroidism <input type="radio"/> Blood thinners |
|---|--|

Are you using any of the following?

- Cigarettes
- Alcohol
- Recreational drugs