PAST MEDICAL HISTORY

Date__________________ Marital Status______________ Years________________

Name__________________ Age___ Husband____________ Age________________

Last menstrual period began__________ How long did it last?________________
-How was it? normal/heavier/lighter -Are your periods regular?____________
-How often? every _____ days. Do you have pain with periods?____________
-What medication do you take for pain?________________________
Age of first period_____ regular______ how often ______ days duration__________

Present type of birth control__________________________ duration__________

Last pap smear_______ List all medications presently taking:__________________
____

Total pregnancies________________ Births__________________________
(Miscarriages) or abortions___________ Dates__________________________
Surgery____
Illness____
Allergies (medications)____
Injuries____

Menopausal symptoms: hot flashes, sleeplessness, depression, nervous (circle)

Have you ever had or have:

	Circle One		Circle One
Heart problems	Yes No	Breast disease	Yes No
Kidney problems	Yes No	Ovarian cyst/tumor	Yes No
Migraine headaches	Yes No	Blood Clots	Yes No
High blood pressure	Yes No	Infections of uterus/tubes/ovaries	Yes No
Jaundice	Yes No	Tumor of uterus	Yes No
Diabetes/abnormal blood sugar	Yes No		

If any of the above are marked "yes", please explain:________________________
____

Immediate family history: Brothers_______________ Sisters__________________

	Circle One		Circle One
Diabetes	Yes No	Heart	Yes No
Cancer	Yes No	Bleeding	Yes No

If any of the above are marked "yes", please explain:________________________
____

Rubella______________ Rubella vaccination: Yes________ No________________
Reason for today's visit:____
____
____
____
____

Patient signature:_____________________________ Date:___________________
Reviewer:____

HOUSTON PERINATAL ASSOCIATES

GENETIC SCREENING FORM

713-791-9700

1. Patient's Name:

____ ______________ _____________
Last First Maiden Date of Birth Blood Type

Father of the baby: ________________________________ ______________
Last First Date of Birth

2. Your occupation: ____

   Father's occupation: ____

3. Have you had any surgeries or chronic illnesses? Have you been on medication for extended periods? If so, please describe: ______________________________________
   ____

4. List children, living or deceased (include those from previous marriages):
   Name Age Sex General Health
   ____
   ____
   ____
   ____
   ____

5. Have you had any miscarriages? ____________________________________
   ____
   Have you had any stillborn infants? If so, please describe: _____________________
   ____

6. Has there been any medication use in the current pregnancy (include prescription, over-the-counter, recreational drugs)? If so, give dates of use, amount, and name of drugs: _______
   ____
   ____

7. Has there been any tobacco use in the pregnancy? __________________________
   How much alcohol has been used in the pregnancy? __________________________
   Has there been any x-ray exposure in the pregnancy? _________________________

8. Have you had any spotting, bleeding, or any other complications? _________________
   ____
   Have you had any illnesses, fever, or unusual rashes in the current pregnancy? _________
   ____

9. Do you have any cats? ____

10. Are you or the baby's father of:
    Greek, Italian, or Asian ancestry? _______________________________
    Jewish ancestry? ____
    Black or East Indian ancestry? _________________________________
    French Canadian/Cajun ancestry? _______________________________

11. Are you and the baby's father blood relatives?________________________________

12. Is there any history in your or the father's family of the following disorders? Include parents, brothers/sisters, nieces/nephews, aunts/uncles, grandparents, and first cousins. If so, mark the blank and list details at the bottom of this page:

_______Birth defects
_______Down syndrome (mongolism)
_______Mental retardation
_______Unexplained infant or childhood deaths
_______Spina bifida (open spine defect)
_______Hydrocephalus (water on the brain)
_______Hemophilia/bleeding disorders
_______Muscle disease (muscular dystrophy)
_______Multiple family members with the same trait or disease
_______Cystic fibrosis
_______Sickle cell disease/trait
_______Huntington's Chorea
_______Multiple miscarriages in relatives
_______Individuals much taller or shorter than the rest of the family
_______Individuals who look unusual or very different
_______Kidney disease
_______Blindness or deafness (congenital)
_______Cleft lip or cleft palate
_______Early onset heart disease (under 35 years)
_______Stillbirths in relatives
_______Early onset cancer (under 35 years)
_______Early onset emphysema (under 35 years)

Details of the above:____
____
____
____
____

13. Do you want to know the sex of the baby?________________________________

14. Do you have any additional concerns not covered above?____________________
____
____
____
____

Patient signature:________________________________ Date:________________

Reviewer:____