OBSTETRIX MEDICAL GROUP

Maternal Fetal Diagnostic Center of Atlanta, Inc.

Patient Name _____ Today's Date _____

Age _____ Birthdate ___/___/____ Reason for today's visit _____

**Menstrual History**

When was your last normal period? _____
How often do you have periods? (28 days, 35 days) _____
If you have ever used birth control, please list the type and dates of use:
_____
_____

**This pregnancy**

What due date is your doctor using? _____
Is your due date based on: Last period date **or** ultrasound

Any problems with this pregnancy? Y N If yes, please describe:
_____
_____

**Previous Pregnancies**

How many times have you been pregnant, including this pregnancy, miscarriages, & abortions? _____
How many babies were born after 37 weeks? _____
How many babies were born before 37 weeks? _____
How many miscarriages have you had? _____
How many terminations (abortions) have you had? _____
How many children are living? _____
How many Ectopic pregnancies? _____

**Please provide ALL previous pregnancy information** (including miscarriages and terminations)

| Date (Month/year) | How far along were you? | Vaginal or C-section | Baby's birth Weight | Complications |
|---|---|---|---|---|
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Patient Name _____ Birthdate _____

**Symptoms** (Please circle any symptoms that you currently have or have had in the past 12 months)

*General*
Fever/Chills
Depression
Fainting
Difficulty sleeping
Nervousness
Sweats
Numbness

*Skin*
Bruise easily
Hives
Rash
Change in moles

*Cardiovascular*
Chest pain
High blood pressure
Low blood pressure
Irregular heartbeat
Heart murmur

*Gastrointestinal*
Poor appetite
Bowel changes
Constipation
Weight loss/gain
Diarrhea
Excessive hunger
Excessive thirst
Hemorrhoids
Nausea
Vomiting
Stomach pain
Heartburn

*Muscle/joints*
Pain/weakness in
_____
Back pain

*Ears, eyes, nose, throat*
Sinus problems
Blurred vision
Double vision
Hayfever
Cough
Ringing in ears

*Genitourinary*
Blood in urine
Painful urination
Frequent urination

*Women's Health*
Abnormal pap smear
Cervix biopsy or surgery
Breasts lump
Vaginal discharge
Vaginal bleeding
Irregular periods
Excessive hair growth

**Conditions** (Please circle any conditions that you currently have or have had in the past 12 months)

Abnormal pap smear
AIDS/HIV
Alcohol/Substance abuse
Asthma
Cancer
Chicken pox
Diabetes
Domestic violence
Epilepsy/Seizures
Heart disease
Hemophilia
Hepatitis
Herpes
High blood pressure
Kidney disease
Liver disease
Migraine headaches
Multiple sclerosis
Psychiatric care
Sexually transmitted disease
Thyroid problems
Tuberculosis
Ulcers
Vaginal infections

**Hospitalizations or surgeries**

| Year | Hospital | Reason/surgery |
|---|---|---|
| | | |
| | | |
| | | |

**Serious Illness or injury**

| Date | Illness or Injury | Outcome |
|---|---|---|
| | | |
| | | |

| | | |
|---|---|---|
| | | |

Patient Name _____ Birthdate _____

**Current Medications** (please list all medications taken w/this pregnancy)

_____
_____
_____

**Allergies(do not leave blank)**

_____
_____
_____

**Genetic Screening**

How old will you be when this baby is born? _____

Have you or the baby's father (from a previous relationship) had 3 or more miscarriages? Yes No

Have any babies in your family been born stillborn Yes No

Are there any known chromosomal disorders in your family? Yes No
If yes, please describe _____

Has anyone in your family or the baby's father's family been born with:

| | | |
|---|---|---|
| Down syndrome | Yes | No |
| Neural tube defect (spina bifida or anencephaly) | Yes | No |
| Hydrocephalus (water on the brain) | Yes | No |
| Hemophilia | Yes | No |
| Muscular dystrophy | Yes | No |
| Heart defect | Yes | No |
| Mental retardation | Yes | No |
| Huntington 's disease | Yes | No |
| Cystic Fibrosis | Yes | No |
| Other (club foot, cleft lip, cleft palate) | Yes | No |

If yes, please explain _____

Certain genetic problems are more common in certain ethnic groups. Please circle your ethnic background:
White (non Hispanic) Black (non Hispanic) Hispanic
American Indian /Alaskan Native Asian/Pacific Islander Other _____

If you or the baby's father is Caucasian or of Jewish ancestry, have You been tested for cystic fibrosis? Yes No N/A
If yes, results are: you _____ father _____

If you or the baby's father is black, have you been tested for sickle cell? Yes No N/A
If yes, results are: you _____ father _____

If you or the baby's father is of Eastern European Jewish descent, have you been tested for Tay-Sachs disease? Yes No N/A
If yes, results are: you _____ father _____

If you or the baby's father is of Asian, Italian, or Greek descent, have you been screened for thalassemia? Yes No N/A
If yes, results are: you _____ father _____

Patient Name _____ Birthdate _____

**Family History**

| Relation | Age | Health status | Age at death | Cause of death | Check if any blood relatives ever had any of the following: | Relationship to you |
|---|---|---|---|---|---|---|
| Father | | | | | Cancer | |
| Mother | | | | | Heart disease | |
| Sibling | | | | | High blood pressure | |
| Sibling | | | | | Kidney disease | |
| Sibling | | | | | Diabetes | |
| Sibling | | | | | | |

**Health Habits** (please circle if you use any of the following and indicate amount):

Caffeine ___ cups/day
Tobacco ___ cigs/pack per day for ____ years
Drugs _____
Other _____

Occupation: _____
Does your occupation expose you to: Stress Heavy lifting Chemical X-ray/radiation Other _____