Medical History and Genetics History Form
Midwest Perinatal Associates

Today's date: _____

Name: _____ Date of birth: _____ Age: _____

Baby's father's name: _____ Age: _____

Referring Physician: _____

In your own words, why have you been referred to us? _____

Your height: _____ Your weight **before** pregnancy: _____

Are you allergic to any medications? ☐ Yes ☐ No If yes, please list:
Are you allergic to latex? ☐ Yes ☐ No _____

_____

Menstrual history: When was the first day of your last menstrual period? _____
Are you certain of this date? ☐ Yes ☐ No
Do you have regular (28-30 day) cycles? ☐ Yes ☐ No
Were you breastfeeding or taking birth control when you became pregnant? ☐ Yes ☐ No
Did you use ART (assisted reproductive therapy) to become pregnant? ☐ Yes ☐ No

When is your due date? _____ This is based on: ☐ last period ☐ early ultrasound ☐ ART

Pregnancy history: Please list all pregnancies from first to last (not including your current pregnancy).

Year	Live Birth Fetal loss after 20 weeks Miscarriage Termination	Type of delivery: Vaginal Cesarean Assisted	Weeks of gestation at delivery	Infant's birth weight	Gender	Pregnancy complications?	Newborn complications?

Gynecologic history: Have you had any of the following? If yes, provide date and additional information.

☐ Yes ☐ No	Laser, cryotherapy of the cervix		
☐ Yes ☐ No	Sexually transmitted infection		
☐ Yes ☐ No	Abnormal Pap smear		
☐ Yes ☐ No	LEEP		
☐ Yes ☐ No	Cold knife conization of the cervix		
☐ Yes ☐ No	Myomectomy		
Other:			

Medications: Please list your current medications (prescription, over-the-counter, herbal preparations, supplements, inhalers).

Medication	Dose	How often taken	Reason

Medical History: Have you had any of the following conditions? If so, include the date of onset and any other information.

☐ Diabetes	☐ Respiratory disease
☐ Thyroid disorder	☐ Blood clots
☐ Polycystic ovarian syndrome (PCOS)	☐ Clotting disorder
☐ High blood pressure	☐ Seizure disorder
☐ Heart disease/defect	☐ Migraine headaches
☐ Kidney disease	☐ Mental health problems
☐ Recurrent urinary/kidney infections	☐ Lupus, or other auto-immune disorders
☐ Hepatitis	☐ Other
☐ Other liver disease:	

Surgical History: Have you had any of the following procedures? If so, please include dates.

☐ Yes ☐ No	Tonsils removed	☐ Yes ☐ No	Cesarean delivery
☐ Yes ☐ No	Gall bladder removed	☐ Yes ☐ No	D&C
☐ Yes ☐ No	Appendix removed	Other:	

Prior hospitalizations: Please list dates and reason of prior hospitalizations (not including childbirth).

Social history: Marital status: ☐ Married ☐ Single ☐ Divorced ☐ Cohabiting ☐ Widowed

☐ Yes ☐ No	Is the baby's father involved/supportive of your pregnancy?	
☐ Yes ☐ No	Are you employed outside the home?	If yes, occupation:
☐ Yes ☐ No	Do you have body piercings or tattoos?	If yes, describe:
☐ Yes ☐ No	Do you smoke/use tobacco?	If yes, amount:
☐ Yes ☐ No	Do you drink alcohol?	If yes, amount:
☐ Yes ☐ No	Do you use recreational/street drugs?	If yes, amount and type:

Review of systems: Please check if you have experience any of the following during this pregnancy. If you have, please include additional information.

☐ Headache	☐ Flu-like symptoms	☐ Abdominal pain
☐ Vision disturbances	☐ Depression, anxiety	☐ Lower back pain
☐ Blurred vision	☐ Numbness	☐ Pelvic pressure
☐ Black spots in vision fields	☐ Loss of sensation	☐ Leaking of fluid from the vagina
☐ Fever	☐ Chest pain	☐ Diarrhea/constipation
☐ Rash	☐ Shortness of breath	☐ Nausea/vomiting

Genetics/family history:

Name: _____

Are you and the baby's father blood relatives? ☐ Yes ☐ No
Have either you or the baby's father ever had a bone marrow or stem cell transplant? ☐ Yes ☐ No
Have either you or the baby's father ever had a stillborn infant? ☐ Yes ☐ No
Have either you or the baby's father ever had a chromosome study? ☐ Yes ☐ No

If yes, what were the results? _____

Have you had genetic screening done during or prior to this pregnancy? Examples include screening for sickle cell disease, cystic fibrosis, fragile X or SMA; pregnancy screening such as first trimester screening, quad screen, non-invasive prenatal testing.

If yes, what were the results? _____

Ethnic background:

		Mother	Father
Are you	Jewish or French Canadian?	☐ Yes ☐ No	☐ Yes ☐ No
	Black or East Indian?	☐ Yes ☐ No	☐ Yes ☐ No
	Asian, Greek or Italian?	☐ Yes ☐ No	☐ Yes ☐ No
	Ethnic background?	_____	_____

Family history: Please indicate if any of these conditions have occurred in you, your family, the baby's father, or the baby's father's family, and to whom (you, baby's father, grandparents, parents, children, sister, brother, nieces or nephews) either living or deceased.

	Mother's side	Father's side		Mother's side	Father's side
☐ Miscarriages/Infertility			☐ Dwarfism or other skeletal disorder		
☐ Stillbirth, infant or childhood death			☐ Hemophilia or other bleeding disorder		
☐ Heart defect found at birth			☐ Stroke and/or blood clotting disorder		
☐ Spina bifida/anencephaly			☐ Sickle cell or thalassemia trait/disease		
☐ Cleft lip and/or palate			☐ Muscular dystrophy		
☐ Other birth defect			☐ SMA (spinal muscular atrophy)		
☐ Intellectual disability/Autism			☐ Cystic fibrosis		
☐ Blindness			☐ Tay-Sachs carrier		
☐ Deafness			☐ Huntington's disease		
☐ Down syndrome			☐ PKU (phenylketonuria)		
☐ Any chromosome disorder			☐ Galactosemia		
☐ Other			☐ Polycystic kidney disease		

Do you have any additional concerns or questions not already covered? _____

Patient's signature: _____ Date: _____

Reviewer's signature: _____ Date: _____