

**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.

<input type="checkbox"/> Yes <input type="checkbox"/> No	Laser, cryotherapy of the cervix		
<input type="checkbox"/> Yes <input type="checkbox"/> No	Sexually transmitted infection		
<input type="checkbox"/> Yes <input type="checkbox"/> No	Abnormal Pap smear		
<input type="checkbox"/> Yes <input type="checkbox"/> No	LEEP		
<input type="checkbox"/> Yes <input type="checkbox"/> No	Cold knife conization of the cervix		
<input type="checkbox"/> Yes <input type="checkbox"/> 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.

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

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

<input type="checkbox"/> Yes <input type="checkbox"/> No	Tonsils removed	<input type="checkbox"/> Yes <input type="checkbox"/> No	Cesarean delivery
<input type="checkbox"/> Yes <input type="checkbox"/> No	Gall bladder removed	<input type="checkbox"/> Yes <input type="checkbox"/> No	D&C
<input type="checkbox"/> Yes <input type="checkbox"/> 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

<input type="checkbox"/> Yes <input type="checkbox"/> No	Is the baby's father involved/supportive of your pregnancy?	
<input type="checkbox"/> Yes <input type="checkbox"/> No	Are you employed outside the home?	If yes, occupation:
<input type="checkbox"/> Yes <input type="checkbox"/> No	Do you have body piercings or tattoos?	If yes, describe:
<input type="checkbox"/> Yes <input type="checkbox"/> No	Do you smoke/use tobacco?	If yes, amount:
<input type="checkbox"/> Yes <input type="checkbox"/> No	Do you drink alcohol?	If yes, amount:
<input type="checkbox"/> Yes <input type="checkbox"/> 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.

<input type="checkbox"/> Headache	<input type="checkbox"/> Flu-like symptoms	<input type="checkbox"/> Abdominal pain
<input type="checkbox"/> Vision disturbances	<input type="checkbox"/> Depression, anxiety	<input type="checkbox"/> Lower back pain
<input type="checkbox"/> Blurred vision	<input type="checkbox"/> Numbness	<input type="checkbox"/> Pelvic pressure
<input type="checkbox"/> Black spots in vision fields	<input type="checkbox"/> Loss of sensation	<input type="checkbox"/> Leaking of fluid from the vagina
<input type="checkbox"/> Fever	<input type="checkbox"/> Chest pain	<input type="checkbox"/> Diarrhea/constipation
<input type="checkbox"/> Rash	<input type="checkbox"/> Shortness of breath	<input type="checkbox"/> 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 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:**

- |         |                            |  |  |
|---------|----------------------------|--|--|
|         |                            | <b>Mother</b>  | <b>Father</b>  |
| Are you | Jewish or French Canadian? | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No |
|         | Black or East Indian?      | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No |
|         | Asian, Greek or Italian?   | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No |

Ethnic background? \_\_\_\_\_

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

	Mother's side	Father's side		Mother's side	Father's side
<input type="checkbox"/> Miscarriages			<input type="checkbox"/> Dwarfism		
<input type="checkbox"/> Stillbirth, infant or childhood death			<input type="checkbox"/> Hemophilia or other clotting disorder		
<input type="checkbox"/> Birth defects			<input type="checkbox"/> Blood clots in immediate family member		
<input type="checkbox"/> Heart defect found at birth			<input type="checkbox"/> Sickle cell trait/disease		
<input type="checkbox"/> Spina bifida			<input type="checkbox"/> Muscular dystrophy		
<input type="checkbox"/> Cleft lip and/or palate			<input type="checkbox"/> SMA (spinal muscular atrophy)		
<input type="checkbox"/> Developmental disability			<input type="checkbox"/> Cystic fibrosis		
<input type="checkbox"/> Blindness			<input type="checkbox"/> Tay-Sachs carrier		
<input type="checkbox"/> Deafness			<input type="checkbox"/> Huntington's disease		
<input type="checkbox"/> Down syndrome			<input type="checkbox"/> PKU (phenylketonuria)		
<input type="checkbox"/> Any chromosome disorder			<input type="checkbox"/> Galactosemia		
<input type="checkbox"/> Other			<input type="checkbox"/> Polycystic kidney disease		

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

Patient's signature: \_\_\_\_\_ Date: \_\_\_\_\_

Reviewer's signature: \_\_\_\_\_ Date: \_\_\_\_\_