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# Obstetrical Screening

Date:____/____/_____ Name: ____________________________________

Age:_______ Date of Birth:____/____/_____ Last Menses:____/____/_______

## Pregnancy History:

| Year | Delivery (vaginal, C/S, Miscarriage, Termination, ectopic) | Gender | Weight | Hospital | Complications |
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Have you undergone infertility treatment? (if yes, please describe):

**Race/ethnicity:**

- White
- Black
- Chinese
- Native American
- Asian-East Indian
- Filipino
- Japanese
- Middle Eastern
- Hispanic
- Other Southeast Asian
- Other
- 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.)

- Sickle cell anemia
- Thalassemia
- Bleeding Disorders (ie: hemophilia)
- Tay Sachs disease
- Cystic fibrosis
- Muscular Dystrophy (or other muscle wasting diseases)
- Spina bifida (openings in the spine)
- Hydrocephalus (“water on the brain”)
- Mental disabilities
- Kidney disease
- Heart malformations
- Down’s syndrome
- Unexplained infant or childhood deaths
- Other birth defects or disorders (describe below)
- Other chromosome disorders (describe below)
- Enzyme or metabolic diseases (ex G6PD def)
- Malformations of the brain
- Malformations of other organs (describe below)
- Diabetes
- Autoimmune disorders (i.e. lupus, rheumatoid arthritis)
- High blood pressure
- Seizures
- Post partum depression
- Hypothyroid disease

Are you taking the following?

- Lithium
- Valium
- Accutane
- Anti-seizures medications
- Iodine to treat hyperthyroidism
- Blood thinners

Are you using the following?

- Cigarettes
- Alcohol
- Recreational drugs