



### Obstetrical Screening

Date: \_\_/\_\_/\_\_

Name: \_\_\_\_\_

Age: \_\_\_\_\_

Date of birth: \_\_/\_\_/\_\_

Last menses: \_\_/\_\_/\_\_

**Pregnancy History:**

Year	Delivery(vaginal, C/S, Miscarriage, termination, ectopic)	Gender	Weight	Hospital	Complications

Have you undergone infertility treatment? (If yes, please describe):

**Race/ethnicity:**

- |                                       |   |   |
|---------------------------------------|---|---|
| <input type="radio"/> White           | <input type="radio"/> Asian-East Indian | <input type="radio"/> Hispanic              |
| <input type="radio"/> Black           | <input type="radio"/> Filipino          | <input type="radio"/> Other Southeast Asian |
| <input type="radio"/> Chinese         | <input type="radio"/> Japanese          | <input type="radio"/> Other                 |
| <input type="radio"/> Native American | <input type="radio"/> Middle Eastern    | <input type="radio"/> 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.)

- |   |   |
|---|---|
| <ul style="list-style-type: none"> <li><input type="radio"/> Sickle cell anemia</li> <li><input type="radio"/> Thalassemia</li> <li><input type="radio"/> Bleeding disorders (i.e. hemophilia)</li> <li><input type="radio"/> Tay Sachs disease</li> <li><input type="radio"/> Cystic fibrosis</li> <li><input type="radio"/> Muscular dystrophy (or other muscle wasting diseases)</li> <li><input type="radio"/> Spina bifida (openings in the spine)</li> <li><input type="radio"/> Hydrocephalus ("water on the brain")</li> <li><input type="radio"/> Mental disabilities</li> <li><input type="radio"/> Kidney disease</li> <li><input type="radio"/> Heart malformations</li> <li><input type="radio"/> Down's syndrome</li> <li><input type="radio"/> Unexplained infant or childhood deaths</li> <li><input type="radio"/> Other birth defects or disorders(describe below)</li> </ul> | <ul style="list-style-type: none"> <li><input type="radio"/> Other chromosome disorders (describe below)</li> <li><input type="radio"/> Enzyme or metabolic diseases (ex G6PD def)</li> <li><input type="radio"/> Malformations of the brain</li> <li><input type="radio"/> Malformations of other organs (describe below)</li> <li><input type="radio"/> Diabetes</li> <li><input type="radio"/> Autoimmune disorders (i.e. lupus, rheumatoid arthritis)</li> <li><input type="radio"/> High blood pressure</li> <li><input type="radio"/> Seizures</li> <li><input type="radio"/> Postpartum depression</li> <li><input type="radio"/> Hypothyroid disease</li> </ul> |
|---|---|

Are you taking any of the following?

- |   |  |
|---|--|
| <ul style="list-style-type: none"> <li><input type="radio"/> Lithium</li> <li><input type="radio"/> Valium</li> <li><input type="radio"/> Accutane</li> </ul> | <ul style="list-style-type: none"> <li><input type="radio"/> Anti-seizures medications</li> <li><input type="radio"/> Iodine to treat hyperthyroidism</li> <li><input type="radio"/> Blood thinners</li> </ul> |
|---|--|

Are you using any of the following?

- Cigarettes
- Alcohol
- Recreational drugs