

Name: _____

GENETIC HISTORY (For Pregnant Patients Only)

Do you, the baby's father or anyone on either side of the family have or ever had any of the following?

	Y	N	If yes, explain.
Age over 35 years at time of delivery			
Thalassemia (Italian, Greek, Mediterranean or Asian)			
Spina Bifida, Meningomyelocele or Anencephaly			
Congenital Heart Defect			
Down Syndrome			
Tay-Sachs (Jewish, Cajun, or French Canadian)			
Canavan Disease			
Sickle Cell Disease or trait (African)			
Hemophilia or other blood disorders			
Muscular Dystrophy			
Cystic Fibrosis			
Huntington's Chorea			
Mental Retardation/ Autism			
Other inherited genetic or chromosomal disorders			
Maternal Metabolic Disorder (i.e. Type I Diabetes, PKU)			
Other birth defects from baby's father			
Recurrent pregnancy loss or stillbirth			
Exposure to medication (including supplements, vitamins, herbs, illicit drugs, alcohol) since last period.			
Exposure to chemicals or radiation (work hazards)			

PERSONAL HISTORY (Continued)

ALLERGIES: List the names of any drugs to which you are allergic and state the reaction you have had:

OPERATIONS: List the operations (major or minor) you have had as well as the hospital location and date:

ILLNESSES OR DISEASES: List the names of any illnesses or diseases you have now or had in the past:

INJURIES OR ACCIDENTS: List any serious injuries or accidents you have had and the date:

PERSONAL AND FAMILY CANCER HISTORY

Do you or any member of your family have or ever had any of the following Cancer

	Y	N	If yes, explain.		Y	N	If yes, explain.
Breast				Ovaries			
Cervix				Colon			
Uterus				Other			

