

**ATLANTA PERINATAL CONSULTANTS
PATIENT HISTORY & SCREENING QUESTIONNAIRE**

Patient Name: _____ Date: _____

First Day of last menstrual period: _____ Estimated Due Date: _____

If pregnancy resulted from fertility treatments, what method?: _____ If Donor Egg pregnancy, age of donor: _____

What will your age be on your due date? _____

Please list # of previous pregnancy(ies): _____

pre-term: _____ miscarriages/ _____

abortions: _____ living: _____

Have you or the baby's father in any previous relationships had 3 or more spontaneous pregnancy losses or a stillbirth? Yes ___ No ___

If yes, please explain: _____

Are you or the baby's father, or anyone in either of your families affected by:

- | | | | |
|--|----------------|------------------------|----------------|
| a. Spina bifida(open spine) or anencephaly | Yes ___ No ___ | g. Hydrocephalus | Yes ___ No ___ |
| b. Hemophilia | Yes ___ No ___ | h. PKU | Yes ___ No ___ |
| c. Muscular Dystrophy | Yes ___ No ___ | i. Cystic Fibrosis | Yes ___ No ___ |
| d. Down syndrome | Yes ___ No ___ | j. Tay Sach's Disease | Yes ___ No ___ |
| e. Mental retardation | Yes ___ No ___ | k. Cleft lip or palate | Yes ___ No ___ |
| f. Heart Defect | Yes ___ No ___ | l. Clubbed foot | Yes ___ No ___ |

Have you, the baby's father, or any relative ever had any birth defect, chromosomal abnormality or inherited health problem not listed above? Yes ___ No ___ If yes, please describe _____

Are you or the baby's father of Jewish, French Canadian or Cajun ancestry? Yes ___ No ___

If yes, have either of you been screened for Tay Sach's disorder? Yes ___ No ___

If yes, please give results: _____

Are you or the baby's father African-American or Latino? Yes ___ No ___

If yes, have either of you been screened for sickle cell carrier status? Yes ___ No ___

If yes, give results: _____

Are you or the baby's father Italian, Greek, Mediterranean, Southern Chinese, Taiwanese or Phillipine background? Yes ___ No ___

If yes, have either of you been screened for thalassemia? Yes ___ No ___

If yes, please give results: _____

Are you and the baby's father related in any way (i.e. cousins)? Yes ___ No ___

Do you have?: a. High blood pressure Yes ___ No ___ e. Lupus Yes ___ No ___

b. Asthma Yes ___ No ___ f. Thyroid disease Yes ___ No ___

c. Diabetes Yes ___ No ___ g. History of blood clots Yes ___ No ___

d. Epilepsy Yes ___ No ___

If yes, please explain: _____

Do you drink alcoholic beverages?: Yes ___ No ___ Number of drinks per week: _____

Do you smoke cigarettes?: Yes ___ No ___ Number of packs per day: _____

Excluding iron and vitamins, have you taken any medications or recreational drugs during this pregnancy? Yes ___ No ___

If yes, please list medications, dosage, and when taken: _____

Have you had an x-ray examination during this pregnancy?: Yes ___ No ___ Please specify: _____

List any surgeries you have had: _____

List any known *DRUG ALLERGIES* you have: [Do Not Leave Blank] _____

Please describe your exercise habits: _____

Please explain any major concerns you have about your pregnancy or family history which are not mentioned above:

Patient Signature: _____