**Medical History Form** Today’s date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Greater Washington Maternal Fetal Medicine & Genetics**

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of birth: \_\_\_\_\_\_\_\_\_\_ Age: \_\_\_\_\_\_

Partner’s name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of birth: \_\_\_\_\_\_\_\_\_\_ Age: \_\_\_\_\_\_

Referring physician: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ OB office location (city): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Religion: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Do you accept Blood transfusions: Yes\_\_\_\_\_\_\_\_\_\_\_\_ No\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Why have you been referred to us?: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you been seen at our office previously?: Yes No *If yes,* when?: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Your height: \_\_\_\_\_\_\_\_\_\_ Your weight **before** pregnancy: \_\_\_\_\_\_\_\_\_\_ Your **current** weight: \_\_\_\_\_\_\_\_\_\_

What is your blood type? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Are you allergic to any medications? Yes No *If yes,* please list:

Are you allergic to latex? Yes No \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Current Pregnancy:**

When was the first day of your last menstrual period?: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

When is your due date?: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ This is based on: last period early ultrasound fertility treatment

Is this a twin/triplet pregnancy?**:**  Singleton Twins Triplets Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Was this current pregnancy achieved by fertility treatment?:** Yes No

Which method was used?: IUI IVF Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

*If IVF*, what type of cycle was it?: Fresh Frozen

*If frozen cycle*, how old were you when you did your egg retrieval?: \_\_\_\_\_ years old

Was this pregnancy achieved by donor egg?: Yes No

 *If yes*, how old was the donor?: \_\_\_\_\_ years old

Was this pregnancy achieved by donor sperm?: Yes No

Was the embryo tested for chromosome disorders?: Yes No

Was the embryo tested for any other genetic disorder?: Yes No *If yes,* what disorder?: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Genetic Testing:**

Have you had genetic screening or carrier screening done during or prior to this pregnancy?: Yes No

Examples include screening for sickle cell disease, cystic fibrosis, fragile X or SMA or pregnancy screening such as first trimester screening, quad screen, non-invasive prenatal testing (NIPT)

*If yes,* what were the results?

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have either you or the baby’s father ever had a chromosome study?: Yes No

 *If yes,* what were the results? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Gynecologic history:** Have you had any of the following? If yes, provide date and additional information.

|  |  |  |  |
| --- | --- | --- | --- |
|  Yes No  | Laser, cryotherapy of the cervix |  |  |
|  Yes No  | Sexually transmitted infection |  |  |
|  Yes No  | Abnormal Pap smear |  |  |
|  Yes No  | LEEP |  |  |
|  Yes No  | Cold knife conization of the cervix |  |  |
|  Yes No  | Myomectomy |  |  |
| Other gynecological surgery: |  |  |  |

**Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Pregnancy history:** Please list all pregnancies from first to last (not including your current pregnancy).

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| Year | *Choose one:**-* Live Birth- Fetal loss after 20 weeks- Miscarriage before 20 weeks- Termination | *Choose type of delivery:*- Vaginal- Cesarean- Forceps/Vacuum | Weeks of gestation at delivery | Infant’s birth weight | Gender | Pregnancy complications? | Newborn complications? |
|  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |

Have you experienced any of the following in a previous or current pregnancy?

 Pre-term labor: previous pregnancy current pregnancy

 High blood pressure/preeclampsia: previous pregnancy current pregnancy

 Diabetes or gestational diabetes: previous pregnancy current pregnancy

 Blood or clotting disorders: previous pregnancy current pregnancy

 Incompetent cervix/cerclage: previous pregnancy current pregnancy

**Medications:** Please list your current medications (prescription, over-the-counter, supplements, inhalers).

|  |  |  |  |
| --- | --- | --- | --- |
| Medication | Dose | How often taken | Reason |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |

Are you taking blood thinners?: Yes No

**Medical History:** Have you had any of the following conditions? If so, include the date of onset.

|  |  |
| --- | --- |
|  Diabetes |  Respiratory disease |
|  Thyroid disorder |  Blood clots/clotting disorder |
|  Polycystic ovarian syndrome (PCOS) |  Seizure disorder |
|  High blood pressure |  Migraine headaches |
|  Heart disease/defect |  Mental health conditions |
|  Kidney disease/recurrent urinary/kidney infections |  Lupus, or other auto-immune disorders |
|  Hepatitis |  Cancer |
|  HIV |  Other: |

Have either you or the baby’s father ever had a bone marrow or stem cell transplant?: Yes No

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

|  |  |  |  |
| --- | --- | --- | --- |
|  Yes No  | Tonsils removed |  Yes No  | Cesarean delivery |
|  Yes No  | Gall bladder removed |  Yes No  | D&C |
|  Yes No  | Appendix removed | Other: |

Have you had a prior hospitalization (not including childbirth)?: Yes No *If so,* list dates and reason.

**Are there any other issues regarding your obstetrical, medical, or family history that we should be aware of?**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

Patient’s signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_