

Palm Beach Obstetrics & Gynecology LLC Genetic History-OB

Name: _____ Date: _____

Date of Birth: _____

This part of the medical record is strictly confidential. It will not be released to any other person or entity without your written authorization.

1. Pregnancy history: None

YES	NO		Number	Year(s)
<input type="checkbox"/>	<input type="checkbox"/>	Miscarriages	_____	_____
<input type="checkbox"/>	<input type="checkbox"/>	Abortions	_____	_____

Year of birth	Weeks of Pregnancy	Length of labor	Baby's weight	Sex	Delivery (check one)		Complications
					Vaginal	C-Section	

2. Genetic history Adopted/Unknown

Do you or your family have any history of the following: (Please write which family member next to diagnosis)

YES	NO		
<input type="checkbox"/>	<input type="checkbox"/>	Downs syndrome	_____
<input type="checkbox"/>	<input type="checkbox"/>	Bleeding problems	_____
<input type="checkbox"/>	<input type="checkbox"/>	Muscle/skeletal problems	_____
<input type="checkbox"/>	<input type="checkbox"/>	Kidney defects	_____
<input type="checkbox"/>	<input type="checkbox"/>	Spine/brain defects	_____
<input type="checkbox"/>	<input type="checkbox"/>	Mental retardation/autism	_____
<input type="checkbox"/>	<input type="checkbox"/>	Learning disabilities	_____
<input type="checkbox"/>	<input type="checkbox"/>	Sickle cell disease	_____
<input type="checkbox"/>	<input type="checkbox"/>	Recurrent pregnancy losses	_____
<input type="checkbox"/>	<input type="checkbox"/>	Epilepsy or seizure disorders	_____
<input type="checkbox"/>	<input type="checkbox"/>	Death of baby at birth or during 1 st year	_____
<input type="checkbox"/>	<input type="checkbox"/>	Cystic Fibrosis	_____
<input type="checkbox"/>	<input type="checkbox"/>	Fragile X Syndrome	_____
<input type="checkbox"/>	<input type="checkbox"/>	Other Birth defects	_____
<input type="checkbox"/>	<input type="checkbox"/>	Other Genetic problems	_____
<input type="checkbox"/>	<input type="checkbox"/>	Are you or your partner related to each other by blood?	_____
<input type="checkbox"/>	<input type="checkbox"/>	Are you or your partner adopted?	_____
<input type="checkbox"/>	<input type="checkbox"/>	Did you get pregnant with the help of infertility treatments?	_____

3. Ethnic background

YES	NO	
<input type="checkbox"/>	<input type="checkbox"/>	Italian, Greek, Spanish, Portuguese, Mediterranean or Middle Eastern ancestry
<input type="checkbox"/>	<input type="checkbox"/>	Jewish, French Canadian or Cajun ancestry
<input type="checkbox"/>	<input type="checkbox"/>	Asian, Indian ancestry
<input type="checkbox"/>	<input type="checkbox"/>	African-American ancestry

Your ethnic background: _____
Ethnic background of the baby's father: _____

4. Social History:

YES	NO	Former	Current	Amount
<input type="checkbox"/>	<input type="checkbox"/>	Tobacco	<input type="checkbox"/>	_____
<input type="checkbox"/>	<input type="checkbox"/>	Alcohol	<input type="checkbox"/>	_____
<input type="checkbox"/>	<input type="checkbox"/>	Drugs	<input type="checkbox"/>	Name: _____
<input type="checkbox"/>	<input type="checkbox"/>	Do you have cats at home?		
<input type="checkbox"/>	<input type="checkbox"/>	Safety concerns at home/Domestic violence		
