Established Patient Prenatal Medical History Form

Today's date ______________________

Appointment date __________________

Name: ____
(First) (Middle) (Last)

Date of Birth: __________________________

Race/Ethnicity/Birthplace ______________________________

Place of Delivery Fairview Southdale Fairview Ridges
(please circle)

LMP (Last Menstrual Period) ______________________________

Date of 1st positive pregnancy test ______________________________

Please complete this form

- Bring to your prenatal class **OR**
- Mail form in the enclosed envelope (1 week prior to your appointment) **OR**
- Fax to Burnsville 952-435-6205
  Edina 952-920-2245

Baby's Physician (if known) ______________________

Father of Baby/Partner ______________________

Would you accept blood products if needed ☐ Yes ☐ No

1. Are you 35 years old or over? ☐ Yes No ☐

Genetic History

2. Thalassemia	☐ Yes	No ☐	If yes, relationship to you ____________
3. Neural Tube Defect (meningomyelocele, spina bifida, anencephaly)	☐ Yes	No ☐	If yes, relationship to you ____________
4. Congenital Heart Disease	☐ Yes	No ☐	If yes, relationship to you ____________
5. Down Syndrome	☐ Yes	No ☐	If yes, relationship to you ____________
6. Tay-Sachs (Jewish, French Canadian)	☐ Yes	No ☐	If yes, relationship to you ____________
7. Canavan Disease	☐ Yes	No ☐	If yes, relationship to you ____________
8. Sickle Cell Disease or Trait	☐ Yes	No ☐	If yes, relationship to you ____________
9. Hemophilia or other blood disorders	☐ Yes	No ☐	If yes, relationship to you ____________
10. Muscular Dystrophy	☐ Yes	No ☐	If yes, relationship to you ____________
11. Cystic Fibrosis	☐ Yes	No ☐	If yes, relationship to you ____________
12. Huntington's Chorea	☐ Yes	No ☐	If yes, relationship to you ____________
13. Mental Retardation/Autism	☐ Yes	No ☐	If yes, relationship to you ____________
If yes, was person tested for Fragile X?	☐ Yes	No ☐	
14. Other inherited genetic or Chromosomal Disorder	☐ Yes	No ☐	If yes, relationship to you ____________

If yes, what? ____

15. Maternal metabolic disorder (DM, PKU, Etc)	☐ Yes	No ☐	If yes, relationship to you ____________
16. Do you or the baby's father have a child with a birth defect not listed above?	☐ Yes	No ☐	If yes, relationship to you ____________
17. Do you or the baby's father have a birth defect?	☐ Yes	No ☐	If yes, relationship to you ____________
18. Recurrent pregnancy loss or stillbirth	☐ Yes	No ☐	If yes, relationship to you ____________
19. Any NEW Medications since Last Menstrual Period	☐ Yes	No ☐	If yes, see reverse side for details
20. Any other genetic/environmental exposure to discuss?	☐ Yes	No ☐	If yes, relationship to you ____________

If yes, what? ____

Infection History / Workplace Environment Risk

1. Live with someone with TB or TB exposed	☐ Yes	No ☐
2. You or partner has history of genital herpes	☐ Yes	No ☐
3. Rash or viral illness since Last Menstrual Period	☐ Yes	No ☐
4. History of STD (Gonorrhea, Chlamydia, Syphilis, HPV, HIV)	☐ Yes	No ☐
5. Exposed to lead, chemicals, or radiation	☐ Yes	No ☐
6. Have you had chickenpox?	☐ Yes	No ☐
7. Are your vaccinations up to date?	☐ Yes	No ☐
8. Are there cats in the home?	☐ Yes	No ☐
9. Exposed to infections at work environment (hospitals, lab work, day care, teaching)	☐ Yes	No ☐
10. Other ______________________	☐ Yes	No ☐
Do you have any history of High Risk Pregnancy or Pregnancy Complications such as Ectopic Pregnancy, Infertility, Gestational Diabetes, High Blood Pressure in Pregnancy, Preterm Delivery, Fetal Anomaly, Placenta Previa, Preterm Labor, C-Section, Twins, VBAC	☐ Yes	No ☐

If yes, please explain ____

____

Comments: ____

Please list below medication that you are currently taking, including herbs, vitamins and supplements

Drug Name	Dosage	Prescribed by whom

Please list any *recent* surgeries since you were seen last

Surgery/Reason	Date

Please list any *recent* Medical Problems

Medical Problem	Date of onset

Social History

Drug	Never	Current	Former
		Amount used	*Age started/Age stopped*
Tobacco			
Caffeine			
Alcohol			
Street/Recreational Drugs			

Partner / Spouse Drug Use? ☐ Yes No ☐

Have you been sexually, physically, emotionally abused, threatened or hurt by anyone? ☐ Yes No ☐