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Direction of Feed

Pregnancy History

Please answer every question

STAFF: *Handwritten items must be entered* ***MANUALLY***.

Marking Instructions

Please use a # 2 pencil
Fill in the complete oval as shown...

PLEASE PRINT PATIENT'S LAST NAME

PLEASE PRINT PATIENT'S FIRST NAME

PATIENT'S DATE OF BIRTH

Month Day Year

RISK FACTORS

Have you ever had chicken pox?		yes ◯	no ◯
Have you ever been exposed to TB (tuberculosis)?		yes ◯	no ◯
Have you ever had a partner with genital herpes?		yes ◯	no ◯
Have you had a rash or viral illness since becoming pregnant?		yes ◯	no ◯
Mark all items that you have taken since becoming pregnant:	medications ◯	drugs ◯	alcohol ◯

GENETIC HISTORY

Please indicate if you, the baby's father, or family have a history of the following:

◯ **My Family History is Unknown**

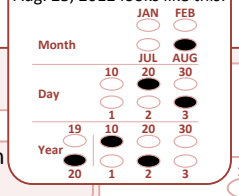
	Mother of Baby	Father of Baby	Family Members of Mother	Family Members of Father
Thalassemia	◯	◯	◯	◯
History of Twins	◯	◯	◯	◯
Neural Tube Defect (e.g., Meningomyelocele, Spina Bifida, Anencephaly, etc.)	◯	◯	◯	◯
Congenital Heart Defect	◯	◯	◯	◯
Down Syndrome	◯	◯	◯	◯
Tay-Sachs (Ashkenazi)	◯	◯	◯	◯
Sickle Cell Disease	◯	◯	◯	◯
Hemophilia	◯	◯	◯	◯
Muscular Dystrophy	◯	◯	◯	◯
Cystic Fibrosis	◯	◯	◯	◯
Huntington Chorea	◯	◯	◯	◯
Mental Retardation	◯	◯	◯	◯

◯ **Family History of Baby's Father is Unknown**

	Mother of Baby	Father of Baby	Family Members of Mother	Family Members of Father
Tested for Fragile X?	◯	◯	◯	◯
Tested Positive for Fragile X	◯	◯	◯	◯
PKU	◯	◯	◯	◯
Diabetes	◯	◯	◯	◯
Cerebral Palsy	◯	◯	◯	◯
Cleft Lip / Palate	◯	◯	◯	◯
Multiple Miscarriages	◯	◯	◯	◯
History of Stillbirth	◯	◯	◯	◯
Had a Child with Other Birth Defect*	◯	◯	◯	◯
Other Genetic or Chromosomal Condition*	◯	◯	◯	◯

***If you chose 'other', please specify:**

EXAMPLE
Aug. 23, 2012 looks like this:



PREGNANCY #1

Sex	◯ male	◯ female	
Outcome	◯ miscarriage	◯ stillbirth	
◯ live birth	◯ abortion	◯ ectopic	
Preterm labor	◯ no	◯ yes	

Weeks pregnant

10	20	30	40					
1	2	3	4	5	6	7	8	9

Type of delivery	◯ c-section	◯ vaginal
	◯ vacuum	◯ forceps
Type of anesthesia	◯ local	◯ spinal
◯ general	◯ epidural	◯ **NONE**

Delivery location / complications / comments

_____

_____

_____

Delivery date

Month

JAN	FEB	MAR	APR	MAY	JUN
JUL	AUG	SEP	OCT	NOV	DEC

Day

10	20	30						
1	2	3	4	5	6	7	8	9

Year

19	10	20	30	40	50	60	70	80	90
20	1	2	3	4	5	6	7	8	9

Length of labor

Hours

10	20	30	40	50	60	70	80	90
1	2	3	4	5	6	7	8	9

Birth weight

Pounds

10	20							
1	2	3	4	5	6	7	8	9

Ounces

10								
1	2	3	4	5	6	7	8	9

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Direction of Feed

Pregnancy History

Please answer every question

STAFF: *Handwritten items must be entered* ***MANUALLY***.

PREGNANCY #2

Sex ○ male ○ female

Outcome ○ miscarriage ○ stillbirth ○ live birth ○ abortion ○ ectopic

Preterm labor ○ no ○ yes

Weeks pregnant 10 20 30 40 / 1 2 3 4 5 6 7 8 9

Type of delivery ○ c-section ○ vaginal ○ vacuum ○ forceps

Type of anesthesia ○ local ○ spinal ○ general ○ epidural ○ NONE

Delivery location / complications / comments

_____

_____

_____

Delivery date

Month JAN FEB MAR APR MAY JUN / JUL AUG SEP OCT NOV DEC

Day 10 20 30 / 1 2 3 4 5 6 7 8 9

Year 19 / 20 — 10 20 30 40 50 60 70 80 90 / 1 2 3 4 5 6 7 8 9

Length of labor 10 20 30 40 50 60 70 80 90

Hours 1 2 3 4 5 6 7 8 9

Birth weight 10 20

Pounds 1 2 3 4 5 6 7 8 9

Ounces 10 / 1 2 3 4 5 6 7 8 9

PREGNANCY #3

Sex ○ male ○ female

Outcome ○ miscarriage ○ stillbirth ○ live birth ○ abortion ○ ectopic

Preterm labor ○ no ○ yes

Weeks pregnant 10 20 30 40 / 1 2 3 4 5 6 7 8 9

Type of delivery ○ c-section ○ vaginal ○ vacuum ○ forceps

Type of anesthesia ○ local ○ spinal ○ general ○ epidural ○ NONE

Delivery location / complications / comments

_____

_____

_____

Delivery date

Month JAN FEB MAR APR MAY JUN / JUL AUG SEP OCT NOV DEC

Day 10 20 30 / 1 2 3 4 5 6 7 8 9

Year 19 / 20 — 10 20 30 40 50 60 70 80 90 / 1 2 3 4 5 6 7 8 9

Length of labor 10 20 30 40 50 60 70 80 90

Hours 1 2 3 4 5 6 7 8 9

Birth weight 10 20

Pounds 1 2 3 4 5 6 7 8 9

Ounces 10 / 1 2 3 4 5 6 7 8 9

PREGNANCY #4

Sex ○ male ○ female

Outcome ○ miscarriage ○ stillbirth ○ live birth ○ abortion ○ ectopic

Preterm labor ○ no ○ yes

Weeks pregnant 10 20 30 40 / 1 2 3 4 5 6 7 8 9

Type of delivery ○ c-section ○ vaginal ○ vacuum ○ forceps

Type of anesthesia ○ local ○ spinal ○ general ○ epidural ○ NONE

Delivery location / complications / comments

_____

_____

_____

Delivery date

Month JAN FEB MAR APR MAY JUN / JUL AUG SEP OCT NOV DEC

Day 10 20 30 / 1 2 3 4 5 6 7 8 9

Year 19 / 20 — 10 20 30 40 50 60 70 80 90 / 1 2 3 4 5 6 7 8 9

Length of labor 10 20 30 40 50 60 70 80 90

Hours 1 2 3 4 5 6 7 8 9

Birth weight 10 20

Pounds 1 2 3 4 5 6 7 8 9

Ounces 10 / 1 2 3 4 5 6 7 8 9

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