Perinatal Diagnostic Centers
of New York and New Jersey

Consultation History

GENERAL INFORMATION

Name: _____ Date of Service: _____

Age: _____ Ethnic Background: _____ Language: _____

Current Weight: _____ Height: _____ Weight before becoming pregnant: _____

Present Problem / Reason for Your Visit: _____

_____

_____

_____

ALLERGIES

Do you have allergies to any medications? Yes ☐ No ☐ If "YES," list and describe reaction:

_____

_____

Do you have any allergies to any food? Yes ☐ No ☐ If "YES," list:

_____

_____

Do you have an allergic reaction to latex? Yes ☐ No ☐

Do you have an allergic reaction to betadine? Yes ☐ No ☐

***Do you consent to receive blood products if necessary to save your life?** **Yes** ☐ **No** ☐

Have you ever received a blood transfusion or blood products? Yes ☐ No ☐

If "YES, please give date and reason for the transfusion: _____

_____

Obstetrical History

Gravida:	Number of pregnancies including the present one:	_____
Parity:	Number of pregnancies delivered at full term (>37 weeks):	_____
	Number of pregnancies delivered at pre term (<37 weeks):	_____
	Number of miscarriages:	_____
	Number of abortions:	_____
	Number of tubal pregnancies:	_____
	Number of live births:	_____

Is this your first pregnancy? **Yes** ☐ **No** ☐

If the answer is "NO," please describe **ALL** of your pregnancies including miscarriages, abortions, and tubal pregnancies. Start with your first pregnancy. Do not include information about the present pregnancy.

Number 1

Date of Delivery: _____ How many weeks or months at the time of delivery? _____

Newborn Sex: _____ Newborn Weight: _____

Hospital: _____ Obstetrician: _____

Type of Pregnancy: Natural: Yes ☐ No ☐ IVF: Yes ☐ No ☐ Clomid: Yes ☐ No ☐

Complications during the pregnancy:

Diabetes: Yes ☐ No ☐ Other Complications of delivery: _____

Pre-Eclampsia: Yes ☐ No ☐ _____

Preterm Labor: Yes ☐ No ☐ _____

Type of delivery:

Vaginal Delivery: Yes ☐ No ☐

Episiotomy: Yes ☐ No ☐ If "YES" then any extensions into rectum? Yes ☐ No ☐

Labor induced: ____ or spontaneous ____ Duration of Labor _____ Type of anesthesia _____

Cesarean Section: Yes ☐ No ☐ If "YES" then indication: _____

Type of C-Section: Lower Uterine Incision ____ Classical Uterine Incision ____

Number 2

Date of Delivery: _____ How many weeks or months at the time of delivery? _____

Newborn Sex: _____ Newborn Weight: _____

Hospital: _____ Obstetrician: _____

Type of Pregnancy: Natural: Yes ☐ No ☐ IVF: Yes ☐ No ☐ Clomid: Yes ☐ No ☐

Complications during the pregnancy:

Diabetes: Yes ☐ No ☐ Other Complications of delivery: _____

Pre-Eclampsia: Yes ☐ No ☐ _____

Preterm Labor: Yes ☐ No ☐ _____

Type of delivery:

Vaginal Delivery: Yes ☐ No ☐

Episiotomy: Yes ☐ No ☐ If "YES" then any extensions into rectum? Yes ☐ No ☐

Labor induced: ____ or spontaneous ____ Duration of Labor _____ Type of anesthesia _____

Cesarean Section: Yes ☐ No ☐ If "YES" then indication: _____

Type of C-Section: Lower Uterine Incision ____ Classical Uterine Incision ____

Number 3

Date of Delivery: _____ How many weeks or months at the time of delivery? _____

Newborn Sex: _____ Newborn Weight: _____

Hospital: _____ Obstetrician: _____

Type of Pregnancy: Natural: Yes ☐ No ☐ IVF: Yes ☐ No ☐ Clomid: Yes ☐ No ☐

Complications during the pregnancy:

Diabetes: Yes ☐ No ☐ Other Complications of delivery: _____

Pre-Eclampsia: Yes ☐ No ☐ _____

Preterm Labor: Yes ☐ No ☐ _____

Type of delivery:

Vaginal Delivery: Yes ☐ No ☐

Episiotomy: Yes ☐ No ☐ If "YES" then any extensions into rectum? Yes ☐ No ☐

Labor induced: ____ or spontaneous ____ Duration of Labor _____ Type of anesthesia _____

Cesarean Section: Yes ☐ No ☐ If "YES" then indication: _____

Type of C-Section: Lower Uterine Incision ____ Classical Uterine Incision ____

Number 4

Date of Delivery: _____ How many weeks or months at the time of delivery? _____

Newborn Sex: _____ Newborn Weight: _____

Hospital: _____ Obstetrician: _____

Type of Pregnancy: Natural: Yes ☐ No ☐ IVF: Yes ☐ No ☐ Clomid: Yes ☐ No ☐

Complications during the pregnancy:

Diabetes: Yes ☐ No ☐ Other Complications of delivery: _____

Pre-Eclampsia: Yes ☐ No ☐ _____

Preterm Labor: Yes ☐ No ☐ _____

Type of delivery:

Vaginal Delivery: Yes ☐ No ☐

Episiotomy: Yes ☐ No ☐ If "YES" then any extensions into rectum? Yes ☐ No ☐

Labor induced: ____ or spontaneous ____ Duration of Labor _____ Type of anesthesia _____

Cesarean Section: Yes ☐ No ☐ If "YES" then indication: _____

Type of C-Section: Lower Uterine Incision ____ Classical Uterine Incision ____

Number 5

Date of Delivery: _____ How many weeks or months at the time of delivery? _____

Newborn Sex: _____ Newborn Weight: _____

Hospital: _____ Obstetrician: _____

Type of Pregnancy: Natural: Yes ☐ No ☐ IVF: Yes ☐ No ☐ Clomid: Yes ☐ No ☐

Complications during the pregnancy:

Diabetes: Yes ☐ No ☐ Other Complications of delivery: _____

Pre-Eclampsia: Yes ☐ No ☐ _____

Preterm Labor: Yes ☐ No ☐ _____

Type of delivery:

Vaginal Delivery: Yes ☐ No ☐

Episiotomy: Yes ☐ No ☐ If "YES" then any extensions into rectum? Yes ☐ No ☐

Labor induced: ____ or spontaneous ____ Duration of Labor _____ Type of anesthesia _____

Cesarean Section: Yes ☐ No ☐ If "YES" then indication: _____

Type of C-Section: Lower Uterine Incision ____ Classical Uterine Incision ____

MEDICAL HISTORY

Asthma: Yes ☐ No ☐ If "YES" For how many years_____ Intubations: Yes ☐ No ☐

Current medications _____

Diabetes: Yes ☐ No ☐ If "YES" For how many years_____Type I____Type II____

Current medications _____

Hypertension: Yes ☐ No ☐ If "YES" For how many years_____

Current medications _____

Lupus or Collagen vascular disease: Yes ☐ No ☐

Current medications _____

DVT (clots in your legs): Yes ☐ No ☐ PE (clots in your lungs): Yes ☐ No ☐

Have you had any of the following medical conditions?

AIDS	Yes ☐	No ☐	Heart trouble/Heart Murmur	Yes ☐	No ☐
Anesthetic Complications	Yes ☐	No ☐	Hepatitis (yellow jaundice)/liver problems	Yes ☐	No ☐
Arthritis	Yes ☐	No ☐	Infertility	Yes ☐	No ☐
HAART Therapy	Yes ☐	No ☐	Kidney or bladder trouble, urinary tract infections	Yes ☐	No ☐
Bleeding disorders	Yes ☐	No ☐	Nervous/emotional problems/depression	Yes ☐	No ☐
Bowel disorders/colitis	Yes ☐	No ☐	Rheumatic fever	Yes ☐	No ☐
Bronchitis/emphysema	Yes ☐	No ☐	Sexual abuse/rape/physical/verbal	Yes ☐	No ☐
Chicken Pox	Yes ☐	No ☐	Stomach problems/ulcers/gastritis	Yes ☐	No ☐
Cancer /Tumors	Yes ☐	No ☐	Stroke or paralysis	Yes ☐	No ☐
D (Rh) Sensitized	Yes ☐	No ☐	Uterine Anomaly/DES	Yes ☐	No ☐
Epilepsy (seizures)	Yes ☐	No ☐	Thyroid gland disease/goiter	Yes ☐	No ☐
Gallbladder/Gallstones	Yes ☐	No ☐	Tuberculosis	Yes ☐	No ☐
Glaucoma	Yes ☐	No ☐	Trauma/Violence	Yes ☐	No ☐
Headaches/Migraines	Yes ☐	No ☐	Varicosities/Phlebitis	Yes ☐	No ☐

List any other serious illnesses or injuries you have had (give dates): _____

_____

_____

Surgical History:

Tonsillectomy	Yes ☐	No ☐
Appendectomy	Yes ☐	No ☐
Abdominoplasty	Yes ☐	No ☐
Gastric Bypass	Yes ☐	No ☐
Gastric Banding	Yes ☐	No ☐
Hernia	Yes ☐	No ☐

Have you had any other surgeries/surgery? Yes ☐ No ☐

If "YES," please give dates, reason for the operation(s) and hospital(s): _____

_____

_____

_____

Gynecologic History:

Name of primary GYN: _____

Age at onset of menstrual cycle: _____ Days between periods _____ Duration of menstrual bleeding _____

Age at the time of first sexual relation _____ Number of partner's _____

Date of last Pap smear: _____ Result _____

Have you ever had abnormal pap smears: Yes ☐ No ☐ If "YES," when? _____

Did you have any treatments? Yes ☐ No ☐ If "YES" then did you have:

Colposcopy: Yes ☐ No ☐ If "YES" then any biopsies and results: _____

Cyrocautery of the cervix: Yes ☐ No ☐ If "YES" then when? _____

LEEP (Loop electro excision procedure) of the cervix: Yes ☐ No ☐ If "YES" then when? _____

CONE Biopsy of the cervix: Yes ☐ No ☐ If "YES"then when? _____

Have you had any sexually transmitted disease (herpes, syphilis, Chlamydia, trichomonas, venereal warts, etc)?

Yes ☐ No ☐ If "YES," when? _____ Did you have treatment? Yes ☐ No ☐

Type of treatment:_____

Have you used oral contraceptives: Yes ☐ No ☐ If "YES" then Name: _____ Duration: _____

Complications with birth control pills: Yes ☐ No ☐ If "YES" please describe below:

_____

Have you ever had an IUD (Intrauterine Device) placed: Yes ☐ No ☐ If "YES" then Type of IUD_____

Date of placement _____ Date of removal _____ Complications _____

Breast Disease: Yes ☐ No ☐ If "YES" then mention:

_____

Mammogram: Yes ☐ No ☐ If "YES" then reason and date, result:

_____

Breast Ultrasound: Yes ☐ No ☐ If "YES" then reason, date, result:

_____

Breast Biopsies: Yes ☐ No ☐ If "YES" the reason, date, result:

_____

Vaccination History:

Seasonal Flu / H1N1 Yes ☐ No ☐ If "YES"date of last administration: _____

Tetanus Yes ☐ No ☐ If "YES"date of last administration: _____

Diphtheria Yes ☐ No ☐ If "YES" date of last administration:_____

Pertussis Yes ☐ No ☐ If "YES" date of last administration: _____

MMR Yes ☐ No ☐ If "YES" date of last administration:_____

Hepatitis B Yes ☐ No ☐ If "YES" date of last administration: _____

Hepatitis A Yes ☐ No ☐ If "YES" date of last administration: _____

HPV Yes ☐ No ☐ If "YES" date of last administration: _____

Meningococcal Yes ☐ No ☐ If "YES" date of last administration: _____

Varicella Yes ☐ No ☐ If "YES" date of last administration: _____

Medications:

List ALL medications that you use on a regular basis, including birth control pills, and non-prescriptions items such as laxatives, over the counter pain medication, cold medication, vitamins, and natural products:

Name: _____ Dose _____ Frequency _____

Name: _____ Dose _____ Frequency _____

Name: _____ Dose _____ Frequency _____

Name: _____ Dose _____ Frequency _____

Patient, baby's father, or anyone in the family with:

YES	NO	RELATIONSHIP	
___	___	_____	Italian, Greek, Mediterranean or Oriental background
___	___	_____	Neural tube defect (open spine)
___	___	_____	Down Syndrome
___	___	_____	Jewish ancestry
___	___	_____	Sickle Cell Disease or Trait
___	___	_____	Hemophilia or other blood disorders
___	___	_____	Muscular Dystrophy
___	___	_____	Cystic Fibrosis
___	___	_____	Huntington's chorea
___	___	_____	Mental Retardation
___	___	_____	Fragile X
___	___	_____	Patient or baby's father has a child with birth defect not listed above
___	___	_____	Congenital heart defects
___	___	_____	TAY-SACHS
___	___	_____	Canavan Disease
___	___	_____	Any other hereditary Ashkenazi Jewish Disorders
___	___	_____	Familial Dysautonomia
___	___	_____	Mental Retardation / Autism
___	___	_____	Maternal Metabolic Disorders (PKU, Type I Diabetes)
___	___	_____	Recurrent pregnancy loss, or a stillbirth

Any other genetic abnormalities and/or syndromes in you, baby's father or your family: YES NO If "YES" then please list: _____

_____

Review of systems: Have you ever had any of the following?

YES	NO	
___	___	Unexpected weight change of more than 10 lbs in the last year?
___	___	Any serious problems with you eyes or ears?
___	___	Any persistent swollen glands or unusual lumps?
___	___	Any breast lumps or nipple discharge?
___	___	Your heart frequently racing or skipping beats?
___	___	Unusual or severe shortness of breath
___	___	Frequent swelling of ankles hands or face?
___	___	Inflamed veins or clots in you veins?
___	___	Is your skin very sensitive to the sun light?
___	___	Frequent coughing or wheezing?
___	___	Serious difficulties swallowing?
___	___	Frequent or severe stomach or abdominal pain?
___	___	Frequent nausea or vomiting?
___	___	Severe constipation or diarrhea?
___	___	Blood in the stool or black stools?
___	___	Unusual skin problems or persistent sores?
___	___	Redness, severe pain or swelling of your joints?
___	___	Frequent or severe back pain?
___	___	Do you bruise easily?
___	___	Have you ever had a severe head injury?
___	___	Have you ever lost consciousness?
___	___	Have you ever broken any bones?
___	___	Have you ever had abnormal periods?
___	___	Have you ever had vaginal infections?
___	___	Have you ever had serious sexual difficulties?
___	___	Have you ever had or do you have serious problems at home or work?
___	___	Have you ever been exposed to poisons, toxins or chemicals, smoke, radioactive materials?

Social History:

Married _____ for how long? _____ Single _____ Divorced _____

Any familial relationship to partner? Yes ☐ No ☐ If "YES" then type of relation _____

Place of birth: _____ Years / months living in New Jersey: _____

Town where you live: _____ Type of Residence: _____

Any pets at home? Yes ☐ No ☐ If "YES" then mention what kind _____

Occupation: _____

Years of education: _____ Level of Education: _____

Recent travel outside the United States over the last 3-4 months: Yes ☐ No ☐ If "YES" then list:

_____

Recent sick contact: YES NO If "YES" then list: _____

Do you smoke? Yes ☐ No ☐ If "YES," how many cigarettes per day? _____

Do you drink? Yes ☐ No ☐ "YES," how many drinks per week? _____

Do you use street drugs? Yes ☐ No ☐ If "YES," when was the last use? _____

What kind of drug? _____ Amount _____

What is the age of the baby's father? _____ is he involved? Yes ☐ No ☐

Current Occupation of partner: _____

Years of education in partner: _____Level of education in partner: _____

Family History:

Has any member of your family had any of the following conditions?

CONDITION	**RELATIONSHIP**
Diabetes	_____
High Blood pressure	_____
Heart Disease	_____
Strokes	_____
Epilepsy	_____
Kidney disease	_____
Blood clots	_____
Preeclampsia	_____
Ovarian Cancer	_____
Colorectal Cancer	_____
Breast Cancer	_____

Any other medical conditions in your immediate family? Yes ☐ No ☐ If "YES" then please list:

_____

_____

I attest that the above information is correct and thoroughly reviewed.

Patients Name: _____

Patients Signature:_____ Date:_____

Physician Signature: _____ Date:_____