Obstetrical Health Screening

Patient Name_____ Date of Birth: _____ Date_____

1. Will you be 35 years or older when the baby is due? Yes____ No____

2. Have you, the baby's father, or anyone in either of your families ever had any of the following disorders?
   - Down syndrome (mongolism) Yes ____ No____
   - Other chromosomal abnormality Yes____ No____
   - Neural tube defect, such as spinal bifida (meningomyelocele or open spine), anencephaly Yes ____ No____
   - Hemophilia Yes____ No____
   - Muscular dystrophy Yes____ No____
   - Cystic Fibrosis Yes____ No____

   If yes, indicate the relationship of the affected person to you or to the baby's father: _____

3. Do you or the baby's father have a birth defect? Yes____ No___
   If yes, what who has the defect and what is it?_____

4. In any previous marriages, have you or the baby's father had a child, born dead or alive, with a birth defect not listed in question 2 above? Yes____ No____
   If yes, what was the defect and who had it? _____

5. Do you, the baby's father have any close relatives with mental retardation? Yes____ No____
   If yes, indicate the relationship of the affected person to you or the baby's father: _____
   Indicate the cause, if known: _____

6. Do you, the baby's father, or a close relative in either family have a birth defect, any familial disorder, or a chromosomal abnormality not listed above? Yes____ No____
   If yes, indicate the condition and the relationship of the affected person to you or to the baby's father: ____
   _____

7. In any pervious marriages, have you or the baby's father had a still born child or three or more first-trimester spontaneous pregnancy losses? Yes____ No____
   Have either of you had a chromosomal study? Yes____ No____
   If yes, indicate who and the results:_____
   _____

8. If you or the baby's father are of Jewish ancestry, have either of you been screened for Tay-Sachs disease? Yes____ No____
   If yes, indicate who and the results: _____
   _____

9. If you or the baby's father are black, have either of you been screened for sickle cell Trait? Yes _____ No____
   If yes, indicate who and the results: _____
   _____

10. If you or the baby's father are Italian, Greek, or Mediterranean background, have either of you been tested for B-thalassemia? Yes____ No____
    If yes, indicate who and the results: _____
    _____

11. If you or the baby's father are of Philippine or Southeast Asian ancestry, have either of you been tested for a-thalassemia? Yes____ No____
    If yes, indicate who and the results: _____
    _____

12. Excluding iron and vitamins, have you taken any medications or recreational drugs since being pregnant or since your last menstrual period? (Include non-prescription drugs). Yes____ No____
    If yes, indicate the name of medication and time taken during pregnancy: _____
    _____