Your Family History- Indicate if anyone in your immediate family has ever had any of these; who; when.

Heart Disease_____
High BP_____
Cancer_____
Diabetes_____
Twins_____
Severe emotional problems_____
Alcohol/drug abuse_____
Other_____

Father of Baby- Indicate if the baby's father has ever had any of these; when.

STD_____
Urethritis_____
Herpes: Genital_____**Oral**_____
Severe emotional problems_____
Alcohol/drug abuse_____
Tobacco use_____
Other_____

Your Mother's History- Please answer the following regarding your mother.

No. of pregnancies_____
No. of live births_____
Miscarriages_____
Any complications_____
Your weight at birth_____
Did she take DES while pregnant with you? Yes____ **No** _____

Questionnaire:
Please answer the following questions which will help determine if there are potential problems to be discussed further. This Information is completely confidential.

Yes No Have you or the father of the baby (FOB) ever had a baby with a birth defect or mental retardation?
Yes No Do you or the FOB have any family members with birth defects or conditions diagnosed as genetic or inherited?
Yes No Are you or the FOB related by blood? (e.g., cousins)
Yes No Are you or the FOB from any of these ethnic/racial groups? (circle)
Jewish Black/African Asian Mediterranean Eskimo Haitian
Yes No Have you or the FOB ever had hepatitis or jaundice?
Yes No Have you ever used any drug intravenously(IV) or had a blood transfusion?
Yes No Have you ever had a sexual partner who used any drug IV, had a blood transfusion or bisexual relations?
Yes No Have you had more than five sexual partners in the last five years?
Yes No Do you think you are at increased risk for having a baby with a birth defect or genetic problem?
Yes No Do you think you are at increased risk for hepatitis?
Yes No Do you think you are at increased risk for AIDS/HIV?
Yes No Have you ever experienced dramatic fluctuations in your weight?
Yes No Have you ever had anorexia, bulimia or an eating problem?
Yes No Is there anything about the development of your sexuality that you would like to discuss?
Yes No Have you ever had severe emotional problems?
Yes No Has anyone ever told you, or do you think, you have ever used alcohol or drugs excessively?

PREVIOUS PREGNANCY HISTORY

total # pregnancies _____ **total # children**_____ **miscarriages/abortions** _____

Previous Pregnancy	First	Second	Third	Fourth	Fifth	Sixth	Seventh	Eighth
Baby's date of birth								
First name								
Birth weight								
Prenatal weight gain								
Gestation (weeks)								
First sign of labor								
Hours active labor								
Time pushing								
Where delivered								
Delivery events								
Breast or bottle								
Birth classes								
Jaundice								
RhoGam given								

NOTES