Personal Information

Name:

Age: Date of birth: day / month / year Ethnic Background:

Occupation: Home Phone: Other Phone:

Father's Name (of baby): Occupation:

Emergency Contact Name: Phone:

Obstetrical History

☐ This is my first pregnancy (If yes, proceed to *Medical History Section*)

☐ Previous Pregnancy (If yes, please complete the chart below, including abortion, stillborn, miscarriage or ectopic pregnancies)

(*Type: Vaginal, C/S, forceps or vacuum *Anaesthesia: Epidural, local, general, spinal *Complications: Diabetes, bleeding, hypertension, etc.)

Year	Location	Weeks	*Type	Length of Labour	Weight	Sex	*Anaesthesia	*Complications	*Preterm Labour
						☐F ☐M			☐Yes ☐No
						☐F ☐M			☐Yes ☐No
						☐F ☐M			☐Yes ☐No
						☐F ☐M			☐Yes ☐No
						☐F ☐M			☐Yes ☐No
						☐F ☐M			☐Yes ☐No

*If preterm labour: were any medications used? ☐

Medical History

Drug Allergies: Reaction:

Current Medications: Last Used: day / month / year Meds Used in Last 6 Months:

From the list below, please indicate if you have any of the following:

Diabetes	☐Yes ☐No	Seizures/CNS	☐Yes ☐No	RH Disease	☐Yes ☐No	Hypertension	☐Yes ☐No
Hepatitis	☐Yes ☐No	Tuberculosis	☐Yes ☐No	Heart Disease	☐Yes ☐No	Phlebitis	☐Yes ☐No
Asthma	☐Yes ☐No	Lupus/Auto Im	☐Yes ☐No	Kidney Disease/UTIs	☐Yes ☐No	Thyroid Disease	☐Yes ☐No
Headaches	☐Yes ☐No	Chicken Pox	☐Yes ☐No	Trauma/Violence	☐Yes ☐No	Psychiatric	☐Yes ☐No
GI Illness	☐Yes ☐No	Blood Transfusion	☐Yes ☐No	Bleeding/Clotting Disorder	☐Yes ☐No	Other:	

Surgical History

Previous Surgical Procedures ☐Yes ☐No (If yes, please indicate the name and date of procedure in the space provided below)

Procedure Name: Date: day / month / year Procedure Name: Date: day / month / year

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Anaesthesia Complications ☐Yes ☐No If yes, please describe: _____

Gynaecology History

Menstruation

Date of your last menstrual cycle: _____ (day / month / year) Was it normal? ☐Yes ☐No

Are your menstrual cycles: ☐regular ☐irregular

Are you periods 'heavy'? ☐Yes ☐No How many days? _____

Was your pregnancy conceived while taking birth control pills? ☐Yes ☐No

Pap Smears

Any abnormal pap smears? ☐Yes ☐No

If yes, any treatment? ☐Yes ☐No

Describe Treatment: _____

Past Infections

Do you have a history of:		Do you or the baby's father have a history of:	
Chlamydia	☐Yes ☐No	Herpes	☐Yes ☐No
Gonorrhoea	☐Yes ☐No	HIV	☐Yes ☐No
UTI's (>3 yrs)	☐Yes ☐No	Hepatitis B	☐Yes ☐No
Syphilis	☐Yes ☐No	Hepatitis C	☐Yes ☐No

Infertility

Is this pregnancy a result of:

Clomid (Serophine Citrate) ☐Yes ☐No

IVF (in Vitro Fertilization) ☐Yes ☐No

Other Reproductive Technology ☐Yes ☐No

Social History

Marital Status: ☐Married ☐Single ☐Engaged ☐Significant Other

Do you consume alcohol? ☐If yes, average amount of drinks per week? _____ Do you smoke? ☐If yes, number of cigarettes per day? _____

Do you use street drugs? ☐If yes, what type and last used? _____

Do you own a cat? ☐If yes, indoor or outdoor? _____ Who changes the litter? ☐You ☐Someone else

Are you in a relationship in which you have any concerns or fears of domestic abuse, either physical or psychological? ☐Yes ☐No

Family History

Please indicate any family history of medical problems, including but not limited to, diabetes, cancer, hypertension, stroke, alcoholism, twins and pregnancy complications:

Parents: _____ Grandparents: _____

Siblings: _____ Other: _____

Did your mother have? ☐History of miscarriages ☐History of DES use

Genetic History

I will be age 35 or older at the time of delivery ☐Yes ☐No

I am interested in genetic counselling ☐Yes ☐No

I have had 3 or more miscarriages ☐Yes ☐No I have had miscarriage workup done ☐Yes ☐No

From the list below, please indicate if you have been tested for the following: (If yes, indicate the results)

Sickle Cell Disease	☐Yes ☐No	☐Negative ☐Positive	Cystic Fibrosis	☐Yes ☐No	☐Negative ☐Positive
Tay-Sachs	☐Yes ☐No	☐Negative ☐Positive	Down Syndrome	☐Yes ☐No	☐Negative ☐Positive
Thalassemia	☐Yes ☐No	☐Negative ☐Positive	Haemophilia	☐Yes ☐No	☐Negative ☐Positive
Neural Tube Defects	☐Yes ☐No	☐Negative ☐Positive	Huntington's Chorea	☐Yes ☐No	☐Negative ☐Positive
Muscular Dystrophy	☐Yes ☐No	☐Negative ☐Positive	Other:		

Do you or the father of the baby have a family history of any of the conditions listed above? ☐Yes ☐No

Please indicate any birth defects or inherited genetic disorders that are not listed above: _____

Comments and Questions: _____

Name :

AHC # :