Austin Maternal-Fetal Medicine			
Patient Last Name (Printed)	Patient First Name (Printed)	MI	Date of Birth (MM/DD/YYYY)

PREGNANCY INFORMATION & HISTORY

Pre-Pregnancy: Height _____ Weight _____	Current Pregnancy: Last Menstrual Period _____	Current Pregnancy: Estimated Due Date _____

Total # Pregnancies	# Term Births (> 37 weeks)	# Premature Births (< 37 weeks)	# Abortions	# Miscarriages	# Ectopic Pregnancies	# Multiple Births (twins, etc)	# Living

#	Month/Year	Weeks Pregnant	Birth Weight	Sex M/F	Delivery Type (vaginal, c-section, vacuum, VBAC, D&C)	Place of Delivery	Comments/Complications (diabetes, hypertension, pre-eclampsia, pre-term labor/delivery, etc)
1							
2							
3							
4							
5							
6							

If there are more than six pregnancies, please use additional sheet.

MEDICAL HISTORY

	Y/N	If yes, please include dates, treatment, and treating physician		Y/N	If yes, please include dates, treatment, and treating physician
Diabetes			Drug or Latex Allergies/Reactions		
Hypertension			Gastrointestinal Disorders		
Heart Disease/Murmur			Anemia/Blood Transfusion		
Stroke/Blood Clots/ Pulmonary Embolism			Hepatitis/Liver Disease		
Kidney Disease/UTI			Depression/Anxiety or Psychiatric Disorder		
Autoimmune Disorder			History of Abnormal Pap		
Neurologic/Seizures (Migraines)			Breast		
Pulmonary (TB, Asthma)			Uterine Abnormalities		
Thyroid Dysfunction			Infertility/Fertility Treatments		

For any relevant family history, please list illness and relationship:

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SURGICAL HISTORY

General Surgery	Yes	No	Comments	General Surgery	Yes	No	Comments
Tonsilectomy				LEEP			
Cholecystectomy				Cold Knife Conization			
Appendectomy				Myomectomy			
Back Surgery				Hysteroscopy			
Gastrointestinal Surgery				Oophorectomy/Cystectomy			
Thyroidectomy				Salpingectomy			
Other				Other			

CURRENT MEDICATIONS/PREFERRED PHARMACY (include vitamins/supplements)

	Medication Name	Dosage & Frequency		Medication Name	Dosage & Frequency
1			4		
2			5		
3			6		

Preferred Pharmacy Name	Preferred Pharmacy Phone Number

If there are more than six medications, please use additional sheet.

SOCIAL HISTORY

	Amt/Day Pre-Pregnancy	Amt/Day Pregnancy	# Years Use
Tobacco Use			
Alcohol Use			
Illicit/Recreational Drug Use			

1	Do you have any allergies? If so, what?
2	Are up on a special diet? If so, list:
3	Have you been or are you in an abusive relationship? □ Yes □ No
4	Will you accept blood products in an emergency? □ Yes □ No
5	Have you ever been exposed to any infectious disease or recently had a rash or fever? □ Yes □ No

GENETIC HISTORY

Personal or Family History	Yes	No	Relationship	Personal or Family History	Yes	No	Relationship
Patients Age >35 Years at Estimated Date of Delivery				Hemophilia or Other Blood Disorders			
Thalassemia (Italian, Greek, Mediterranean or Asian Background) MCV <80				Muscular Dystrophy/Neuromuscular Disease			
Neural Tube Defect (Spina Bifida, Anencephaly or Meningomyelocele)				Cystic Fibrosis			
Congenital Heart Defect				Huntington's Chorea			
Down Syndrome				Mental Retardation or Autism (If yes, were they tested for Fragile X? □ Yes □ No			
Tay Sachs (Jewish, Cajun, French Canadian)				Cleft Lip/Cleft Palate			
Canavan Disease				Consanguinity (Related)			
Sickle Cell Disease or Trait (African)				Other Inherited Chromosonal Disorder Not Listed			

GENETIC SCREENING

Have you or your partner had carrier testing or have you had any of the following tests? Please circle:

Cystic Fibrosis	You	Partner	First Trimester Screen	Yes	No
Spinal Muscular Atrophy (SMA)	You	Partner	Cell Free DNA (Harmony, Panorama, etc)	Yes	No
Fragile X	You	Partner	Chorionic Villus Sampling (CVS)	Yes	No
Other Genetic Disorders	You	Partner	Amniocentesis (Amnio)	Yes	No

If yes, what test and where was this test performed?

Would you like any of the above testing or other testing not listed? Please list tests:

Is there anything else you would like us to know that will impact your medical care?