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Medical & Family History Form – Prenatal

A personal and family history are taken to see if there are concerns, ***other than the reason you were referred to us***, which should be discussed. **Please print clearly.**

PREGNANT PATIENT

- Last Name:_____ First Name:_____
- Occupation:_____ Telephone #:_____
- First day of your last menstrual period (LMP) (yr/mo/day)?_____/_____/_____
- How old will you be on your due date?_____
- Current Weight (kg/lb):_____ If no current weight, it will be measured in clinic.
- Current Height (cm/in):_____
- Please list any additional healthcare providers that are/will be involved in your pregnancy:

  _____
- Were assisted reproductive techniques used for conception (eg. IVF, ICSI, IUI, other - please specify)?

  ☐ Yes ☐ No If other: _____

  If YES, was a donor egg/donor sperm/donor embryo used? ☐ Yes ☐ No

  - Sperm donor ☐ Yes ☐ No
  - Egg donor ☐ Yes ☐ No
  - Donor embryo ☐ Yes ☐ No

  Was the donor/embryo screened for genetic diseases? (eg.. cystic fibrosis) ☐ Yes ☐ No

Answer 'yes' if true since becoming pregnant:	**Yes**	**No**
Have you taken any medications? If yes, list here:		
Have you had any illness and/or infection?		
Have you had any fever higher than 38° C (101° F), or used a sauna or hot tub?		
Have you had any x-rays?		
Have you been exposed to any hazardous materials at work or at home?		
Do you smoke? If yes, when and how much (packs/day)?		
How much alcohol have you consumed? When and how much (glasses/day)?		
Have you used any recreational drugs (cannabis, cocaine etc.)? If yes, what, when, and how much?		

- **PREGNANCY HISTORY:**

  Total number of pregnancies (including this one)_____

  Number of Children_____

  Number of Stillbirths_____

  Number of Miscarriages_____ at how many weeks?_____

  Ectopic Pregnancies_____

  Number of Abortions_____

  Do you have any adopted children? ☐ Yes ☐ No If yes, how many?_____

  Have you or your partner or donor had a pregnancy in which malformation (ie.,structural defects/ differences) were diagnosed in the baby? ☐ Yes ☐ No

  If yes, please explain:_____

PATIENT'S PARTNER

- Last Name:_____ First Name:_____
- Date of Birth (yr/mo/day):_____/_____/_____
- Occupation:_____

BOTH PATIENT AND PARTNER

- What country(ies) are you and your ancestors from? This information may be used to offer you ancestry based screening.

  You/egg donor_____

  Your Partner/sperm donor:_____

- Are you/donor and your partner/donor related by blood? (eg. cousins) ☐ Yes ☐ No
- Are you adopted? ☐ Yes ☐ No Is your partner adopted? ☐ Yes ☐ No
- Do you or your partner or donor have a known medical condition, or were either of you born with any physical differences? If so, please describe.

  _____

  _____

FAMILY HISTORY

- Is there a known family history of any of the following conditions? Please check all that apply.

	Your Family/Donor	Partner/Donor Family	Who is Affected?
Cystic Fibrosis	☐	☐	_____
Bleeding disorder	☐	☐	_____
Muscular Dystrophy	☐	☐	_____
Birth defects	☐	☐	_____
Other physical differences	☐	☐	_____
Down syndrome	☐	☐	_____
Fragile X	☐	☐	_____
Intellectual disability	☐	☐	_____
Multiple miscarriages	☐	☐	_____
Other genetic/familial conditions	☐	☐	_____

Have you/donor or your partner/donor or family members ever had any genetic testing? ☐ Yes ☐ No
If yes, please explain_____

Please list anything else that is a concern to you:

_____

_____

_____

Patient signature:_____ **Date:**_____