# LAUREL WHITE, MD, PC
## Pregnancy information

**Name** _____ **Father of Baby** _____
**Birth date** _____ **Age** _____ **Birth date** _____ **Age** _____
**Occupation** _____ **Occupation** _____
**Ethnic Origin** _____ **Ethnic Origin** _____
**Name of MD or Midwife:** _____ **MD Office Location:** _____

**What is the reason for your visit?** _____

**History of This Pregnancy**
Date you last menstrual period started: _____ Sure? Yes/No Date your baby is due: _____
How tall are you? ____ Feet ____ inches What was your weight around the time you became pregnant? _____ (BMI___)
Difficulty conceiving? Yes/No *Check if yes:* Medication __ IUI __ IVF __ (If donor ova were used how old was she? _____ )
Bleeding: Yes/No Fever over 101.4F: Yes/No Vomiting: Yes/No Hospitalization: Yes/No Why? _____
Have you had an ultrasound so far during this pregnancy? Yes/No If Yes, where? _____
Have you been tested for Down syndrome or other chromosome problems? Yes/No
If Yes, check all you have had: 1st Tri Screen (PAPP-A)? __ NIPT (Cell-Free DNA) ___ Quad Screen (AFP) __ Amnio or CVS ___
List ALL medications you take now _____

**Menstrual History**
At what age did you start having menstrual periods? ____ For 6 months prior to this pregnancy were they regular? Yes/No
How many days does your period usually last? ____ days How often do your periods usually come? Every ____ days.

**Exposures**
Do you smoke cigarettes? _____ How many cigarettes per day? _____ If you ever smoked, when did you quit? _____
Do you drink alcohol? _____ How many days a week? _____ How many drinks per day? _____
Do you use marijuana? _____ If yes, how often? _____Cocaine? _____ If yes, How often? _____
Do you use any other illegal drugs? _____ Have you been exposed to radiation at work? _____
Do you have cats? _____ Do they go outdoors? _____ Do you clean the litter box? ___ Are you exposed to raw meat? ____

**Allergies to Medications: (list):**_____ **Latex Allergy:** Yes/No

**Work**
How many hours do you work per day? _____ Do you work with young children or handicapped adults? Yes/No

**Obstetrical History**
Including this pregnancy, how many times have you been pregnant? ___ How many living children do you have? _____
Number of miscarriages _____ Number of abortions _____ Number of ectopic or molar pregnancies _____
Have you had any stillborn babies? Yes/No Babies that died within a year of birth? Yes/No

**For Each Baby Delivered after 24 Weeks (6 months)**

| Delivery Date | Sex | Birth Weight | Method of Delivery | Weeks Pregnant at Birth | Complications |
|---|---|---|---|---|---|
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |

**For Each Miscarriage**

| Month/Year | Weeks Pregnant | Bleeding? | Cramping? | Infection? | Other Problems | Was D&C Necessary? |
|---|---|---|---|---|---|---|
| | | | | | | |
| | | | | | | |
| | | | | | | |

**PLEASE COMPLETE NEXT PAGE**

**Social History**

List the people who live with you: _____

Do you follow an exercise regimen? Yes/No Wear glasses/lenses? Yes/No Do you have regular dental checkups? Yes/No

Have you had any recent motor vehicle accidents or other accidents? Yes/No When: _____

Has anyone hit, kicked or punched you or made you afraid in the past 12 months? Yes/No When: _____

**Past Medical History** *Have you ever had any of the following problems? If yes, what year was the problem diagnosed?*

Diabetes
Thyroid disease _____
High blood pressure_____
Heart disease _____
Asthma _____
Tuberculosis _____
Epilepsy (seizures) _____
Autoimmune disease _____
Depression _____
Anxiety _____
Other Psychiatric Problems _____
Stroke _____
Blood clots in the legs or lungs _____
Hepatitis or other liver disease _____
Cystic Fibrosis Carrier _____ Tay Sachs Carrier _____

Bleeding disorder_____
Anemia _____
Kidney disease _____
Cancer *(type and year)* _____
Sexually transmitted disease _____
Genital herpes infection _____
HIV infection _____
Cytomegalovirus infection _____
Uterine abnormality_____
Abnormal Pap smear _____
Operations *(list)* _____
LEEP or Cervical Cone Biopsy _____
Blood Transfusions _____
Periodontal (Gum) Disease _____
Sickle Cell Carrier _____ Other Genetic Disease _____

Other problems not listed above: _____
_____

**Baby's Father's History**

Medical Problems _____
Congenital Heart Defect _____ Other Birth Defect _____
Cystic Fibrosis Carrier _____ Tay Sachs Carrier _____ Sickle Cell Carrier _____ Other Genetic Disease _____

**Family History** *Please list any medical problems in your family or the baby's father's family. (Names not necessary)*

Your Mother _____
Your Father _____
Your Sisters _____
_____
Your Brothers _____
_____
Your Mother's Mother _____
Your Mother's Father _____
Your Father's Mother _____
Your Father's Father _____

Partner's Mother _____
Partner's Father _____
Partner's Sisters _____
_____
Partner's Brothers_____
_____
Partner's Mother's Mother _____
Partner's Mother's Father _____
Partner's Father's Mother _____
Partner's Father's Father _____

*Does anyone in your family or in the baby's father's family have any of the following problems? If so, who?*

Congenital heart disease (heart defect at birth) _____
Spina bifida _____
Other birth defects _____
Mental retardation _____
Down syndrome _____
Trisomy 18 _____
Trisomy 13_____
Fragile X Syndrome _____
Other chromosome abnormality _____
Hemophilia (bleeding problems) _____
Thrombophilia (clotting problems) _____
Muscular dystrophy _____

Cystic fibrosis _____
Spinal Muscular Atrophy _____
Huntington's chorea _____
Familial Dysautonomia _____
Canavan Disease _____
Sickle cell anemia _____
Thalassemia _____
Tay-Sachs disease_____
Three or more miscarriages _____
Stillborn baby _____
Small for gestational age baby _____
Baby that died in infancy _____

**Do you have any other questions or concerns? _____**

_____