Genesee Valley Obstetrics and Gynecology, P.C.

Name ______________________________ Date ______________________
Date of Birth ______________ Medication Allergies ______________________
Primary Care Physician ______________________ Pediatrician ______________________

Husband/Father of the Baby's Information:

Name ______________________________ Phone Number ______________________
Occupation ______________________ Any Health Problems ______________________

Emergency Contact Other Than Husband or Father of the Baby:

Name ______________________________ Relation ______________________
Phone Number ____

Previous Pregnancies:

Total Number of Pregnancies __________ Number of Living Children ______________
Any Birth Defects? ____
Any Complications with Pregnancies? ______________________________

List Deliveries:

Date Mo/Yr	Length of Labor	Birth Weight	Type of Delivery	Place of Delivery	Sex M/F	Baby's Name	Comments/ Complications

Menstrual History:

First Date of Your Last Menstrual Period ______________ Certain [] Yes [] No
Age When Periods Began __________ How Often Do You Have a Period ______________
How Long Do Your Periods Last ______________ Are Your Periods [] Regular [] Irregular
What Method of Birth Control Have You Used Over the Past Year ______________________

Infection History:

	Yes	No		Yes	No
Live with Someone with TB or Exposed to TB			Rash or Viral Illness since Last Menstrual Period		
Patient or Partner Have a History of Genital Herpes			History of STD: GC, Chlamydia, HPV, Syphilis		

Comments: ____
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Medical History:

Please Mark a (Y) for Yourself or (F) for Family Member

Diabetes		Thyroid Dysfunction		History of Abnormal Pap Smears	
Hypertension		Major Accidents		Uterine Anomaly	
Heart Disease		History of Blood Transfusion		Infertility History	
Chicken Pox		Tobacco		DES Exposure	
Mitral Valve Prolapse		Alcohol		Autoimmune Disorder	
Kidney Disease/ UTI		Street Drugs		Trauma/Domestic Violence	
Neurologic/Epilepsy		Over The Counter Drugs		Breast Disease	
Psychiatric		Tuberculosis		Operations/Hospitalizations	
Hepatitis/Liver Disease		Asthma		Year & Reason	
Varicosities/Phlebitis		Anesthetic Complications			

Comments: ____

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Genetics Screening

(Includes Patient, Baby's Father or Immediate Family Members in Either Family)

	Yes	No		Yes	No
Are you older than 35			Cystic Fibrosis		
Thalassemia (Italian, Greek, Mediteranean or Oriental Background)			Congenital Heart Defect		
Neural Tube Defect (Open Spine, Meningomyelocele or Anencephaly)			Mental Retardation		
Trisomy 21			Other Inherited Genetic or Chromosomal Disorder		
Tay-Sachs (Eg. Jewish Background)			You or Baby's Father Has a Child With Birth Defects Not Listed		
Sickle Cell Disease or Trait			More than 3 First-Trimester Spontaneous Abortions or a Stillbirth		
Hemophilia			Maternal Metabolic Disorder (i.e. Diabetes, PKU)		
Muscular Dystrophy					

Comments: ____

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Reviewed with Patient______________________

Sign and Date