

Please fill out and bring with you.

PRENATAL GENETIC COUNSELING HISTORY SHEET

Name _____ Age _____ Race _____ Religion _____

Blood Type _____ Reason for Referral _____

Occupation: _____ Spouse/Partner Occupation: _____

What countries did your ancestors come from? _____

What countries did your partner's ancestors come from? _____

Menstrual History:

What was the first day of your last menstrual period? _____

Do you know when conception occurred? _____

How frequent are your periods? _____

Do you have any problems with them? _____

Any other GYN problems? _____

Have you had an operation on your uterus or cervix (neck of the womb)?

During This Pregnancy:

Have you had any problems? _____

Have you had any bleeding? _____

Have you taken any medications (prescription or over-the-counter)? _____

Have you used any drugs (cocaine, heroin, etc.)? _____

Do you have any drug, food or latex allergies? _____

How much do you smoke? _____

How much alcohol do you drink? _____

(Continue on reverse)

During This Pregnancy (continued from previous page):

Have you had any infections (herpes, hepatitis, etc.)? _____

Have you been tested for HIV (AIDS virus?) _____ Result? _____

Have you had any shots? _____

Have you had any X-rays? _____

Have you had any other exposures? _____

Was this pregnancy planned or a surprise? _____

How do you feel about the pregnancy? _____

How do you feel in general? _____

Your Pregnancy History:

How many previous pregnancies? _____

How many children? _____

How many miscarriages? _____

Other pregnancy outcomes? _____

Family History: Please consider your family and your partner's family when answering.

Miscarriages? _____

Stillbirths? _____

Infant deaths? _____

Birth defects? _____

Intellectual disability (formerly known as mental retardation)? _____

Genetic conditions? _____