ObGyn of East Brunswick
By Women For Women
an Axia Women's Health Care Center

172 Summerhill Rd
East Brunswick, NJ 08816
P/ (732) 254-1500
www.obgyneb.com

1. Name_____DOB_____Birthplace_____
Last First Maiden

Occupation_____Religion_____

Baby's Father_____DOB_____Birthplace_____
Last First

Occupation_____Religion_____

2.

Are you, or the baby's father, or any of your parents or grandparents of:	Baby's Mother's Side		Baby's Father's Side		If yes, have either been tested for:			Any History in Family	
	Yes	No	Yes	No		Yes	No	Yes	No
Italian, Greek, Hispanic, or Middle Eastern ancestry?					Beta-thalassemia				
Jewish, French Canadian, or Cajun ancestry?					Tay Sach's Gaucher's Cystic Fibrosis Canavan's				
Black/African American ancestry?					Sickle-Cell				
Philippine, Asian or Indian ancestry?					Alpha-thalassemia				
Northern European ancestry?					Cystic Fibrosis				

3. Are you and the baby's father blood relatives? Yes _____ No _____
If yes, specify_____
4. Have you or the baby's father had any surgeries or chronic illness? Yes _____ No _____ If yes, describe_____
5. Have you or the baby's father been medicated for extended periods? Yes _____ No _____ If yes, describe_____
6. List children, living, deceased (include those from either parent's previous partnership).

Name	Age	Sex	Health Problems (if any)

7. Have you had any miscarriages? Yes_____ No_____ If so, when and how far pregnant? _____
Have you had any stillborn infants? Yes_____ No_____ If so, when and how far pregnant? _____
8. Has either parent had a chromosome study? Yes_____ No_____ If yes, results _____
9. Have you taken any medications during the current pregnancy?
(Include prescription, over-the-counter, recreational drugs) Yes_____ No_____
If yes, name of drugs Amounts Dates of Use
_____ _____ _____
_____ _____ _____
_____ _____ _____

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10. Has there been any tobacco use during pregnancy? Yes_____ No_____

    If yes, amount and dates_____

    Has there been any alcohol consumption during the current pregnancy? Yes_____ No_____

    If yes, amount and dates_____

11. Have you been exposed to any infections, x-rays, immunizations, toxic chemicals, or had a rash or fever during the current pregnancy? Yes_____ No_____

    If yes, describe_____

12. Do you or the baby's father have a birth defect? Yes_____ No_____

    If yes, describe_____

    Do you or the baby's father have any children or family members with a birth defect? Yes_____ No_____

    If yes, describe_____

13. Do you live with someone with tuberculosis or have you been exposed to TB? Yes_____ No_____

14. Have you, the baby's father, or any blood relative in either family had any of the following disorders? Include parents, children, brothers, sisters, grandparents, aunts, uncles, nieces, nephews, and cousins.

Disorders	You	Baby's Father	Children	Your Relatives	Baby's Father's Relatives	None	Specify
Seizure Disorder							
Hearing Loss (not with old age)							
Blindness							
Mental Retardation							
Mental Illness							
Diabetes							
Cystic Fibrosis							
Heart Disease							
Short Statue Growth Disorders							
Bleeding Problems							
Anemia							
Kidney Disease							
Gastrointestinal Problems							
Muscular Dystrophy							
Neural Tube Defect (open spine)							
Down's Syndrome							
Other Chromosome Abnormality							
Other Genetic Problems							
Recurrent Miscarriages							
Hemophilia							
Phenylketonuria							
Huntington's Chorea							

15. Do you have any pets, or frequent contact with animals? Yes_____ No_____

    If yes, specify_____

16. Do you eat raw meat or fish? Yes_____ No_____
17. Have you ever had an amniocentesis, CVS or other prenatal diagnosis? Yes_____ No_____

    If yes, specify_____

18. How many servings of dairy products do you have daily? _____

_____ _____
Patients Signature *Date*

_____
Reviewed by