

Please fill in the information on the other side
Perinatal Center of Oklahoma

John R. Stanley III, MD

Charles P. Mirabile JR, MD

Jennifer G. Smith, MD

Name: _____ Date of Visit: _____ Date of Birth: _____

Age@ this delivery: _____ Date of last menstrual cycle: _____ Due Date: _____ Race: _____

Age of Father of baby: _____ Reason for visit / Current Problem: _____

Total No of pregnancies (including this one): _____ Term Deliveries (37 weeks or more): _____

Preterm deliveries (before 37 weeks): _____ Miscarriages: _____ Abortions: _____

Total No of living children: _____ Previous Cesarean sections: _____

Have you had an Ultrasound with this pregnancy? If yes, at how many weeks? _____

Have you had any complications or other problems with your current pregnancy?: _____

Have you had any complications or problems with a prior pregnancy?: _____

Current medical problems? (Example diabetes, epilepsy, high blood pressure, asthma, depression, thyroid dysfunction, hepatitis): _____

Past medical problems? (including tuberculosis exposure and STD's) _____

Have you ever had surgery? (Please list type of surgery and year performed): _____

Current medications and dosage (Please include over the counter medications and herbal supplements): _____

Allergies to medications or latex: _____

Do you drink any alcohol, smoke or use any recreational drugs: _____

Have you had the First trimester screen for Down Syndrome and Trisomy 13/18? If yes do you know the results of your test?(10-13 weeks) _____

Have you taken the Maternal Serum screen for Down Syndrome, Spina Bifida and Trisomy 18 - If yes When and do you know the results?(15-20 weeks) _____

Have you ever received a blood transfusion? _____

Have you ever been told you had a uterine anomaly or abnormal pap smear? _____

Do you have any questions or concerns you would like to discuss with the physician today? _____

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Have either you or a family member ever seen a genetic counselor or a medical geneticist before?

Yes

No

If yes, Where and for what reason? _____

Are you and the father of the baby related by blood ?

Yes

No

Have you or any member of either family ever had:

Patient's Family

Father of Baby

A child with mental retardation?

Yes No

Yes No

A child with Down Syndrome?

Yes No

Yes No

A child with a chromosomal problem?

Yes No

Yes No

Learning problems or developmental delay?

Yes No

Yes No

Cleft lip and / or palate?

Yes No

Yes No

Heart defect?

Yes No

Yes No

Spina Bifida, Skull Defect or Anencephaly?

Yes No

Yes No

Cystic Fibrosis?

Yes No

Yes No

Have you been screened for Cystic Fibrosis w/ this pregnancy?

Yes No

Yes No

Muscle or Neuromuscular disease?

Yes No

Yes No

Hemophilia?

Yes No

Yes No

Sickle cell anemia, Thalassemia or other blood disorder?

Yes No

Yes No

Kidney Disorder?

Yes No

Yes No

Huntington's Disease?

Yes No

Yes No

Tay Sach's, Canavan disease, or Familial Dysautonomia?

Yes No

Yes No

Any birth defects or genetic diseases not listed above?

Yes No

Yes No

If you answered "yes" to any of the above questions, Please state how the affected individual is related to you and any known details about their condition. _____

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