OBGYN ULTRASOUND
A PROGRAM OF THE DELAWARE CENTER FOR MATERNAL FETAL MEDICINE OF CHRISTIANA CARE

Date: _____

Patient Name: _____ Patient DOB: _____ Occupation: _____

Patient Height: _____ Patient Pre-Pregnancy Weight: _____

**Race**: ☐ Native American or Alaskan Native ☐ Asian ☐ Native Hawaiian or Other Pacific Islander

☐ Black or African American ☐ White ☐ Hispanic ☐ Other: _____

Partner Name: _____ Partner DOB: _____ Occupation: _____

**Race**: ☐ Native American or Alaskan Native ☐ Asian ☐ Native Hawaiian or Other Pacific Islander

☐ Black or African American ☐ White ☐ Hispanic ☐ Other: _____

**If you do not wish any of this history to be discussed in front of your family members or any guests in the room, please note that below or notify any of our staff at your earliest convenience.**

## Medical History

| | | | | | |
|---|---|---|---|---|---|
| ▸ Do you currently have? | Diabetes | **Y N** | Are you on Medications for this? | **Y N** |
| Do you currently have? | Hypertension | **Y N** | Are you on Medications for this? | **Y N** |
| Do you currently have? | Thyroid issues | **Y N** | Are you on Medications for this? | **Y N** |
| ▸ Do you currently have? | Seizures | **Y N** | Are you on Medications for this? | **Y N** |
| Do you currently have? | Crohns/UC | **Y N** | Are you on Medications for this? | **Y N** |
| Do you currently have? | Lupus | **Y N** | Are you on Medications for this? | **Y N** |
| Do you currently have? | Asthma | **Y N** | Are you on Medications for this? | **Y N** |
| ▸ Do you currently have? | Clotting disorder | **Y N** | Are you on Medications for this? | **Y N** |
| ▸ Do you have a history of? | A blood clot/stroke | **Y N** | Are you on Medications for this? | **Y N** |
| ▸ Do you have a history of? | Heart problems | **Y N** | Are you on Medications for this? | **Y N** |

Please specify

Do you have any other medical condition we should be aware of? _____

What are your current medications? (please include dosage of medication if available)

| ▸ Medication | Dosage | ▸ Medication | Dosage | ▸ Medication | Dosage |
|---|---|---|---|---|---|
| | | | | | |
| | | | | | |
| | | | | | |

**Allergies:** _____

## Pregnancy History

| | | | |
|---|---|---|---|
| What is your due date for this pregnancy? | | | |
| Have you had an ultrasound already in this pregnancy? | **Y N** | If yes, date: | |
| How many times have you been pregnant including this pregnancy? | | | |
| How many living children do you have? | | | |
| Have you had any miscarriages? | **Y N** | If yes, how many: | ▸ (If 3 or more) |
| Have you had any terminations/discontinuation of pregnancy? | **Y N** | If yes, how many: | |
| ▸ Were any of the terminations due to fetal abnormality or genetic condition? | **Y N** | | |
| How many vaginal deliveries have you had? | | | |
| How many c-sections have you had? | | | |
| Have you ever had twins or triplets? | **Y N** | | |
| Have you had any children pass away? | **Y N** | | |
| Did any of your children have to go the Neonatal Intensive Care Unit? | **Y N** | | |
| In any of your pregnancies did you have problems with high blood pressure or preeclampsia? | **Y N** | | |
| In any of your pregnancies did you have problems with gestational diabetes? | **Y N** | | |

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▸ *Genetic counseling indication*

# Medical Screening Form

**Please continue on reverse**

| | | |
|---|---|---|
| In any of your pregnancies did you have problems with your baby measuring too small? | Y | N |
| In any of your pregnancies did you have problems with your amniotic fluid being too low or too high? | Y | N |
| In any of your pregnancies did you have preterm labor? | Y | N |
| Were you hospitalized in any of your pregnancies? | Y | N |
| Did you deliver any of your children preterm (before 37 weeks or more than 3 weeks before your due date)? | Y | N |
| Do you have a history of cervical incompetence or problems with your cervix? | Y | N |
| Have you ever had surgery on your cervix (cerclage, LEEP, cone biopsy)? | Y | N |
| Are you aware of any problems with your uterus (abnormal shape, fibroids, uterine surgery)? | Y | N |
| Are you aware of any problems with your ovaries (PCOS, cysts, masses, tumors)? | Y | N |

**Pregnancy Exposure History** (Any time during the pregnancy, including prior to knowledge of the pregnancy)

| | | |
|---|---|---|
| ▸ Have you been exposed to any radiation since you knew you were pregnant? | Y | N |
| ▸ Have you been exposed to any alcohol during this pregnancy ? | Y | N |
| ▸ Have you used any tobacco (cigarettes, e-cigarettes, chew tobacco)? | Y | N |
| ▸ Have you used any marijuana? | Y | N |
| ▸ Have you used any other recreational drugs (Heroin, Cocaine, Methamphetamines)? | Y | N |
| ▸ Are there any medications you stopped once you found out you were pregnant? | Y | N |
| Are you taking, or have you taken any herbal medications or supplements? | Y | N |

**Pregnancy Exposure History**

| | | |
|---|---|---|
| ▸ Will you be 31 or older at delivery if you are carrying twins, triplets, etc. | Y | N |
| ▸ Will you be 35 or older at the time of delivery? | Y | N |
| ▸ Was your partner 45 or older at the time of conception? | Y | N |
| ▸ Were either you or your partner born with a birth defect or physical difference? | Y | N |
| ▸ Were any of your children born with a birth defect or physical difference? | Y | N |
| ▸ Are you or your partner related to each other by blood (i.e cousins) | Y | N |
| ▸ Do you have any Ashkenazi Jewish ancestry? | Y | N |
| ▸ Does your partner have any Ashkenazi Jewish ancestry? | Y | N |
| ▸ Have you had carrier testing? | Y | N |

**Are you or your partner a carrier for any of the following?**

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| ▸ Cystic Fibrosis | Y | N | Not Tested | ▸ Spinal Muscular Atrophy | Y | N | Not Tested |
| ▸ Sickle Cell Disease | Y | N | Not Tested | ▸ Alpha Thalassemia | Y | N | Not Tested |
| ▸ Beta Thalassemia | Y | N | Not Tested | ▸ Fragile X Syndrome | Y | N | Not Tested |
| ▸ Tay Sach's Disease | Y | N | Not Tested | ▸ Any other genetic conditions? | Y | N | Not Tested |

**Were you or your partner, either your children or your partner's children, or any other family members on either side (parents, siblings, nieces, nephews, grandparents, aunts, uncles, cousins) born or diagnosed with any of the following? (If yes, specify who was affected)**

| Condition | | | Relationship | Condition | | | Relationship |
|---|---|---|---|---|---|---|---|
| ▸ Down Syndrome | Y | N | | ▸ Missing/Extra Chromosome | Y | N | |
| ▸ Intellectual Disabilities | Y | N | | ▸ Fragile X syndrome | Y | N | |
| ▸ Autism/ASD | Y | N | | ▸ Blindness | Y | N | |
| ▸ Hearing Loss | Y | N | | ▸ Cystic Fibrosis | Y | N | |
| ▸ Spinal Muscular Atrophy | Y | N | | ▸ Sickle Cell Anemia | Y | N | |
| ▸ Alpha/Beta Thalassemia | Y | N | | ▸ Tay Sach's Disease | Y | N | |
| ▸ Muscular Dystrophy | Y | N | | ▸ Hungtington's Disease | Y | N | |
| ▸ Blood Clotting Disorder | Y | N | | ▸ Bleeding Disorder | Y | N | |
| ▸ Neurofibromatosis | Y | N | | ▸ Spina Bifida/Anencephaly | Y | N | |
| ▸ Hydrocephaly | Y | N | | ▸ Heart Defect | Y | N | |
| ▸ Kidney Defect | Y | N | | ▸ Polycystic Kidney Disease | Y | N | |
| ▸ Genital Anomalies | Y | N | | ▸ Cleft Lip/Palate | Y | N | |
| ▸ Diaphragmatic Hernia | Y | N | | ▸ Abdominal Wall Defect | Y | N | |
| ▸ Limb/Hand/Foot/Finger/Toe Abnormality | Y | N | | ▸ Other Birth Defect | Y | N | |
| | | | | ▸ Other Genetic Condition | Y | N | |

If you answered yes to any question, please explain:

▸ *Genetic counseling indication*