

Palm Beach Obstetrics & Gynecology PA
Genetic History-OB

Name: _____

Date: _____

Date of Birth: _____

This part of the medical record is strictly confidential. It will not be released to any other person or entity without your written authorization.

1. Pregnancy history: None

Miscarriages Number Year(s)
 Abortions _____ _____

Date	Weeks of Pregnancy	Length of labor	Baby's weight	Sex	Delivery		Complications
					Vaginal	C-Section	

2. Genetic history Unknown (Please write which family member next to diagnosis)

- Down's syndrome _____
- Bleeding problems _____
- Muscle problems _____
- Spine defects _____
- Mental retardation _____
- Sickle cell disease _____
- Birth defects _____
- Other Genetic problems _____

- Jewish ancestry
- African-American ancestry

- Your ethnic background: _____
- Ethnic background of the baby's father: _____

3. Social History: None

	Former	Current	Amount
<input type="checkbox"/> Tobacco	<input type="checkbox"/>	<input type="checkbox"/>	_____
<input type="checkbox"/> Alcohol	<input type="checkbox"/>	<input type="checkbox"/>	_____
<input type="checkbox"/> Drugs	<input type="checkbox"/>	<input type="checkbox"/>	_____

- Do you have cats at home
- Safety concerns at home/Domestic violence