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OBSTETRICS MEDICAL ASSESSMENT FORM

Name_____ **Date**_____ **Chart No**._____

In order for us to provide informed prenatal care, it is important for you to answer these questions. All information is held in strict confidence.

	Yes	**No**
1. Will you be age 35 or older when this baby is born?	___	___
2. Will the father be age 50 or older when this baby is born?	___	___
3. Have you, the baby's father, or anyone in either of your families ever had any of the following disorders?:	___	___
A. Down's syndrome (mongolism), any chromosomal abnormality?	___	___
B. Neural tube defect (spina bifida, meningocele, myelocele, encephalocele, open spine), or anencephaly?	___	___
C. Hemophilia, muscular dystrophy, cystic fibrosis?	___	___
D. Birth Defects?	___	___
E. Mental Retardation?	___	___
4. Have you or the baby's father ever had 3 or more pregnancies that ended in miscarriage before the 4th month?	___	___
5. Have either of you had a chromosomal study? If yes, indicate who and the results: _____	___	___
6. Have you or the baby's father ever had a stillborn?	___	___
7. Do you fall in one of the following categories?	___	___
A. Work in a public safety field?	___	___
B. Have frequent occupational exposure to blood?	___	___
C. Have contact with a known Hepatitis B carrier or hemodialysis patient?	___	___
8. Are you or the baby's father of Eastern European (Ashkenazi) Jewish ancestry?	___	___
9. Are you or the baby's father African-American or African? If yes, have either of you been screened for sickle cell disease? ___	___	___
10. Are you or the baby's father of Italian, Greek, Mediterranean, Philippine, or Southeast Asian ancestry?	___	___
11. Are you and the baby's father related in any way (e.g. cousins)?	___	___
12. Do you drink alcohol? If yes, how much: _____	___	___
13. Do you smoke? If yes, how much: _____	___	___
14. Have you taken any "street drugs"? If yes, which: _____	___	___
15. During this pregnancy, have you taken any medicine or had x-rays?	___	___
16. Have you been told you have genital herpes?	___	___
17. Are you currently in an abusive situation?	___	___
17. Have you been told you carry Group B strep (in the vagina or urine)?	___	___
18. Have you ever had a premature baby (3 weeks or more early)?	___	___
19. Have you ever had a baby 2 or more weeks overdue? ___	___	
20. Have you ever had Chicken Pox? If no, vaccine? _____	___	___

Physician: _____ Date:_____