Questionnaire for new obstetrical patients

1. What was the first day of your last menstrual period? _____
   Are your periods regular? _____ How many days apart are your periods? _____

2. Do any of your parents, siblings, or children have diabetes or hypertension? _____

3. How many times have you been pregnant? ___ How many children? ___Please list below

Name	birthdate	Hospital/Doctor	birthweight	vag or C/S?	Problems?

4. Do you have any allergies (including medications)?

5. Please list any surgeries that you have had.

6. Have you ever had any of the following medical problems?

	Yes	No		Yes	No		Yes	No
Kidney disease	___	___	Venereal disease	___	___	phlebitis/varicose veins	___	___
Heart disease	___	___	gynecologic problems	___	___	Epilepsy	___	___
High blood pressure	___	___	anxiety or depression	___	___	blood disease	___	___
Rheumatic fever	___	___	Diabetes	___	___	blood transfusions	___	___
Tuberculosis	___	___	thyroid disease	___	___			

7. Have you had any of the following symptoms during this pregnancy?

	Yes	No
Vaginal bleeding	___	__
Vaginal discharge	___	___
Abdominal pain	___	___
Urinary problems	___	___

8. Are you drinking alcohol during this pregnancy? Yes ___ No ___
9. Do you smoke cigarettes? Yes ___ No ___
10. Do you use recreational drugs? Yes ___ No ___
11. Do you have any cats or do you eat raw meat? Yes ___ No ___
12. Have you had any X-rays during this pregnancy?
    (Ultrasounds/sonos are not X-rays) Yes ___ No ___

Name_____**Date**_____

1. Will you be 35 years or older when the baby is due? ..... Yes ____No____
2. Have you, the baby's father, or anyone in either of your families ever had any of the following disorders?

- Down Syndrome (mongolism)…… Yes____No____
- Other chromosomal abnormality ..... Yes ____No____
- Neural tube defect, ie, spina bifida(meningomyelocele or open spine), anencephaly Yes ____No____
- Hemophilia ..... ……Yes ____No____
- Muscular Dystrophy ..... Yes ____No____
- Cystic Fibrosis ..... Yes ____No___
- Huntington disease……Yes____No____
- Conjenital heart defects (heart defects at birth)……Yes____No____

  If yes, indicate the relationship of the affected person to you or the father of your baby:_____

3. Do you or the father of the baby have a birth defect? ..... Yes ____No____
   If yes, who has the defect and what is it?_____
4. In any previous marriages, have you or the baby's father had a child born dead or alive, with a birth defect other than those listed in question 2 above? ..... Yes ____No_____
   If yes, who had the defect and what was it?_____
5. Do you or the baby's father have any close relatives with mental retardation? ..... Yes ____No_____
   If yes, indicate the relationship of the affected person to you or the baby's father:
   Indicate the cause, if known: _____
   Have you or the baby's father ever been tested for "Fragile X " syndrome? …..... Yes ____No_____
6. Do you, the baby's father, or a close relative in either of your families have a birth defect, any familial disorder, or a chromosomal abnormality not listed above? ..... Yes ____No_____
   If yes, indicate the condition and the relationship of the affected person to you or the baby's father: _____
7. In any previous marriages, have you or the baby's father had a stillborn child or three or more first trimester spontaneous pregnancy losses? ..... Yes ____No_____
   Have either of you had a chromosomal study? ..... Yes ____No_____
   If yes, indicate who and the results: _____
8. Are you or the baby's father of Jewish, French Canadian, or Cajun ancestry? ..... Yes____No_____
   If so, have either of you been screened for Tay - Sachs disease? ..... Yes____ No____
   If yes, indicate who and the results: _____
9. Has anyone in your (or the baby's father's) family ever had Canavan disease, Familial dysautonomia, Niemann-Pick disease, Fanconi anemia, Bloom syndrome, Mucolipidosos Type IV, or Gaucher's disease……...Yes____No____
10. Are you or the baby's father black? ..... Yes____ No____
    If so, have either of you been screened for sickle cell trait? ..... Yes ____No____
    If yes, indicate who and the results:_____
11. Are you or the baby's father of Italian, Greek or Mediterranean background? ..... Yes____No____
    If so, have either of you been tested for *b*-thalassemia (Mediterranean anemia)? ..... Yes ____No____
    If yes, indicate who and the results:_____
12. Are you or the baby's father of Philippine or Southeast Asian ancestry? ..... Yes ____No____
    If so, have either of you been tested for *a*-thalasssemia? ..... Yes ____No____
    If yes, indicate who and the results:_____
13. Excluding iron and vitamins, have you taken any medication or recreational drugs since being pregnant or since your last menstrual period? (including nonprescription drugs) ..... Yes ____No____
    If yes, give name of medication/drug and time taken during pregnancy:_____

Testing for Chromosomal Abnormalities

Amniocentesis (done at about 16 weeks) or CVS (done at about 11 weeks) are the only methods that find almost all chromosomal problems. Both of these tests, however, are invasive and can cause a miscarriage. Please note that they do not test for all birth defects or genetic problems. You can read about chromosomal problems, amniocentesis, and CVS on our website in the "Testing for chromosomal & genetic disorders" section.

Non-invasive tests for chromosomal problems are "screening tests" that provide you with your risk of having a baby with certain chromosomal problems. None of these tests, however, give you a clear "yes or no" answer. They simply tell you what your chance is for having a baby with certain problems (like Down syndrome). For example, a non-invasive test may tell a woman that her risk of having a baby with Down syndrome is one in 200 or one in 3000. Most patients who are told that they are at increased risk of Down syndrome do not really have a problem (they have a "false positive").

Screening tests are only able to screen for three of the most frequent problems (Down syndrome, Trisomy 18 and Trisomy 13) and will not be positive in all patients who have a fetus with these disorders. Amniocentesis and CVS are diagnostic tests and can detect all types of chromosomal problems.

Screening tests are done at three different stages of your pregnancy:

1. At the end of the first trimester (approx. 11 to 13 ½ weeks), blood test results are combined with an ultrasound (nucal translucency). This is the best non-invasive test for chromosomal abnormalities. Many (or most) women will choose to start with this test.
2. Maternal serum AFP*4* (quad screen) done at 16 to 18 weeks. This blood test can be drawn in our office. You will receive a pamphlet explaining this test in more detail at the visit prior to 16 weeks.
   This test can be combined with the first trimester test (the modified sequential test) to give one result which detects more cases of chromosomal problems than either test alone.
3. A "genetic" ultrasound done by a perinatologist (high-risk obstetrician) at about 20 weeks.

We strongly recommend genetic counseling for all pregnant women who may be interested in pursuing testing for chromosomal or genetic (hereditary) problems. As you can see, the options can be confusing, and genetic counseling can help decide which choice is right for you.

Please sign below in the appropriate place.
I wish to go for genetic counseling _____
I do not wish to go for genetic counseling _____

Please let one of the doctors know if (usually after going for genetic counseling) you wish to have any of the above mentioned testing.

CARRIER SCREENING FOR GENETIC DISEASES IN ASHKENAZI JEWS

Testing is available for a number of genetic disorders which are more common in people of Ashkenazi Jewish descent. After reading the informational pamphlet on these disorders, please sign in the appropriate place below:

I acknowledge that I have read and understand the pamphlet on Jewish disorders and:

Neither the baby's father nor I are Jewish _____

We (or one of us) are Jewish but decline to be tested _____
We (or one of us) are Jewish and we wish to be tested. _____

Please be aware that most patients will wish to complete all genetic testing (on both parents) as soon as possible so as to leave adequate time to test the baby for these disorders (if necessary).

HIV Testing

1. In December, 2007, New Jersey became the latest state to make HIV testing part of routine prenatal care for all pregnant patients.

2. HIV is the virus that causes aids and it is transmitted through unprotected sex, or through sharing of needles through injection drugs use.

3. A pregnant woman who has HIV can pass the virus to her baby before or during birth or by breast feeding. Women, especially, may not know they are at risk. Many women get HIV through heterosexual sex and are not aware that their partners have been at risk for HIV.

4. There are important benefits for a woman to knowing whether she has HIV or not. HIV is treatable. Treatment can prolong a woman's life and prevent transmission to her baby during pregnancy and birth.

5. Experts recommend that all pregnant women be tested for HIV regardless of whether a woman thinks she is at risk. If a woman is HIV positive, she can get treatment immediately. The CDC has found medical intervention during pregnancy can cut the mother-to-child HIV transmission from 25 percent to 2 percent.

6. All information about HIV testing and the results are kept confidential. In New Jersey, results are reported to the state Department of Health and Senior Services, where they are kept strictly confidential. Federal and state laws protect women with HIV from discrimination.

7. A woman has the right to refuse testing and she will not be denied care if she does so. If a woman refuses screening, NJ law requires that her newborn be directly tested shortly after birth.

8. If you do not refuse testing now, you will be tested around the time of your first visit and again around 28 weeks (so as to comply with New Jersey law).

9. If you refuse testing you will be asked again around 28 weeks. If you are not tested around 28 weeks, you will be asked again when admitted to the hospital. If you are still not tested, your baby will be tested (unless you document a religious objection).

I acknowledge that I have read the above.

Date _____ Signature_____

Name (please print)_____

For Patients who decline HIV testing, sign below

I have decided to decline HIV testing _____