The Corvallis Clinic™

**Patient Name:** _____

**Partner Name:** _____

**Date:** _____

# OB/GYN Family History

Welcome to our OB/GYN Department! We thank you in advance for completing the below history form that will help guide us through your initial prenatal visit. We hope to discuss measures that will help you have a healthy pregnancy. We also want to identify any possible concerns that may arise in your pregnancy.

In chronological order, please list all of your previous pregnancies. List the earliest one first. Please include all pregnancies, including livebirths, stillbirths, miscarriages, ectopic, and terminations.

**PREVIOUS PREGNANCIES**

| No. | Date | Gestational Length | Labor Hours | Type Delivery | Anesth | Sex | Wt. | PLACE OF Delivery | Complications |
|---|---|---|---|---|---|---|---|---|---|
| **1** | | | | Choose One... | Choose one... | | | | |
| **2** | | | | Choose One... | Choose one... | | | | |
| **3** | | | | Choose One... | Choose one... | | | | |
| **4** | | | | Choose One... | Choose one... | | | | |
| **5** | | | | Choose One... | Choose one... | | | | |

**LMP (First date of last menstrual period):** _____

**Please check "yes" or "no" if there is a family history of the following conditions: Who?**

| Yes | No | History | |
|---|---|---|---|
| ☐ | ☐ | Diabetes | |
| ☐ | ☐ | Hypertension | |
| ☐ | ☐ | Renal Disease | |
| ☐ | ☐ | Cancer | |
| ☐ | ☐ | Twins | |
| ☐ | ☐ | Heart Disease | |
| ☐ | ☐ | Lung Disease | |
| ☐ | ☐ | Seizure Disorder | |
| ☐ | ☐ | Other | |

**Please See Reverse**

| To help us determine if your baby will inherit a gene that can lead to a serious illness, please check "yes" or "no" if there is a possibility that you or the father may have the following condition in your family: | Yes | No | Notes |
|---|---|---|---|
| 1. Thalassemia (Italian, Greek, Mediterranean, or Asian Background): MCV < 80 | ☐ | ☐ | |
| 2. Neural Tube Defect (Meningomyelocele, Spina Bifida, or Anencephaly) | ☐ | ☐ | |
| 3. Heart Defect in a newborn baby | ☐ | ☐ | |
| 4. Down Syndrome | ☐ | ☐ | |
| 5. Tay-Sachs (eg, Jewish, Cajun, French-Canadian) | ☐ | ☐ | |
| 6. Canavan Disease | ☐ | ☐ | |
| 7. Sickle Cell Disease or Trait (typically of African heritage) | ☐ | ☐ | |
| 8. Hemophilia or other Blood Disorders | ☐ | ☐ | |
| 9. Muscular Dystrophy | ☐ | ☐ | |
| 10. Cystic Fibrosis (typically of Caucasian descent) | ☐ | ☐ | |
| 11. Huntington's Chorea | ☐ | ☐ | |
| 12. Intellectual Disability/Autism | ☐ | ☐ | |
| 13. If yes, was person tested for Fragile X? | ☐ | ☐ | |
| 14. Other Inherited Genetic or Chromosomal Disorder | ☐ | ☐ | |
| 15. Maternal Metabolic Disorder (eg, Type 1 Diabetes, PKU) | ☐ | ☐ | |
| 16. Patient or baby's father had a child with Birth Defects or Conditions Not Listed Above | ☐ | ☐ | |
| Please check "yes" or "no" if you have the following risk factors: | Yes | No | Notes |
| 1. Will you be 35 years or older when you deliver this pregnancy? | ☐ | ☐ | |
| 2. Have you had 3 or more miscarriages? | ☐ | ☐ | |
| 3. Do you live with someone who may have tuberculosis, TB? | ☐ | ☐ | |
| 4. Do either you or your partner have had genital herpes? | ☐ | ☐ | |
| 5. Have you had a rash or viral illness since you have been pregnant? | ☐ | ☐ | |
| 6. Have you ever had chlamydia, gonorrhea, HPV, syphilis, hepatitis or HIV? | ☐ | ☐ | |
| 7. Have had a baby born with Group B Strep infection? | ☐ | ☐ | |
| 8. Have you had chicken pox or the vaccine against chicken pox? | ☐ | ☐ | |
| 9. Have you tested positive for MRSA, methicillin resistant staph infection within the past 3 years? | ☐ | ☐ | |
| 10. Have you traveled outside of the country? | ☐ | ☐ | |
| 11. Is there a family history of getting clots in the legs or lungs? | ☐ | ☐ | |