

UT Southwestern Medical Center

Department of Obstetrics and Gynecology
Maternal-Fetal Medicine at
Children's Medical Center Legacy

Medical Information

Pt. Name: _____

Address: _____

City _____ State _____ Zip _____

MRN: _____

DOB: _____

SSN: XXX-XX-____ Sex: _____

DOS: _____

Name: _____ Age: _____ Date: _____

Referred by: _____

Reason for referral: _____

No Yes

What is your due date? _____

- Have you had an ultrasound this pregnancy?
- Have you had a first or second trimester screening test (eg., for Down syndrome; spina bifida)?
- Have you had PGS, CVS, or amniocentesis this pregnancy?
- Is this pregnancy the result of egg or sperm donation?
- Are you a gestational carrier/surrogate?

OB History

Please tell us about all pregnancies, even if you had an early miscarriage, ectopic, pregnancy termination, or stillbirth.

Year	Fertility Treatment	Gestational Age*	Pregnancy or Delivery Complications	Mode of Delivery vaginal / c-section	Weight	Sex	Newborn or Subsequent Health Issues
_____	N / Y	_____	_____	_____	_____	M / F	_____
_____	N / Y	_____	_____	_____	_____	M / F	_____
_____	N / Y	_____	_____	_____	_____	M / F	_____
_____	N / Y	_____	_____	_____	_____	M / F	_____

*Gestational age at time of demise, termination, or delivery.

No Yes

- Is the biologic father of this pregnancy the same as prior pregnancies?

Gyn History

No Yes

No Yes

- Do you have predictable, regular periods? Do you have any uterine anomaly (e.g., bicornuate)?
- Do you have a diagnosis of PCOS? Do you have fibroids?
- Do you have a history of herpes?
- Have you ever had a LEEP, cold knife cone, or other cervical excision procedure?
- Have you ever had gonorrhea, chlamydia, or syphilis?

Allergies: (drug, food, latex, etc.) Please list reaction. _____

Current medications: (List all vitamins, supplements, herbals, over-the-counter, and prescription medications.)

No Yes

- Are your vaccinations up to date? (MMR, seasonal influenza, tetanus)
- Have you had chicken pox or the varicella vaccine?



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Surgeries/Procedures

Please list any surgeries or procedures involving anesthesia.

Operations	Year	Any Non-Childbirth Hospitalizations	Year
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

No Yes

Have you had any anesthesia or bleeding complications?

Medical History Have you ever had:

No Yes

High blood pressure

Diabetes

Thyroid disease

Depression

Anxiety

Other psychiatric illness

Blood clot/DVT

Gallbladder disease

No Yes

Anemia

Asthma or lung disease

Heart disease

Heart murmur

Sickle cell disease

Hepatitis B or C

Blood transfusions

Rh(D) sensitized

No Yes

HIV

Autoimmune disease

Cancer

Kidney disease

Tuberculosis

Uterine infections

Seizures/epilepsy

Migraine headaches

Eating disorders

Please list any other medical problems: _____

Family/Genetic History (Family of biologic mother and biologic father of **this pregnancy**)

Ethnicity of biologic mother _____ Ethnicity of biologic father _____
of **this pregnancy** of **this pregnancy**

No Yes

Are the biologic parents of this pregnancy related to each other (1st cousins or closer)?

Have you had carrier testing (eg., cystic fibrosis, spinal muscular atrophy, fragile X, etc.)?

Are you or the father of the baby of Ashkenazi Jewish descent?

Have you or any relative (including the father and his family) ever had:

No Yes

Diabetes

High blood pressure

Heart disease

Heart attack

Blood clot in leg or lung

Sickle cell disease

Stroke

Thalassaemia

Recurrent pregnancy loss

No Yes

Hemophilia

Spina bifida

Congenital heart defect

Cleft lip/palate

Clubfoot

Autism

Neurodevelopmental delay

Fragile X syndrome

Spinal muscular atrophy

No Yes

Down syndrome

Muscular dystrophy

Cystic fibrosis

Huntington chorea

Tay Sachs

Canavan disease

Metabolic disorder (PKU, Gaucher)

Other genetic disorder



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Social/Environmental

What is your occupation? _____

No Yes

Do you exercise? What frequency and form? _____

Do you observe any kind of special diet (e.g., vegetarian)? _____

Have you consumed alcohol in this pregnancy? If so when and how much? _____

Have you used any recreational drugs in this pregnancy? If so, which ones and how much? _____

Have you EVER used tobacco?

Do you use tobacco products now? If so, which form and how much? _____

Have you ever abused alcohol or drugs? Please explain. _____

Any known toxin, chemical, or radiation exposures? _____

Are you being abused in any way (physical, verbal, sexual)?

Is there anything else you would like the doctor to know? _____

Is there anything in your history above that you do not want discussed in the presence of your family or friends? _____

Emergency Contact

Name: _____ Phone number: _____

Relationship: _____