CSOUTHERN COLORADO MFM

Southern Colorado Maternal Fetal Medicine

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Family and Exposure History Questionnaire

Name:	DOB:	Date:
Please bring this form with you to your appointment. If you have been	n to our office during	a previous pregnacy,
please update family history with new information and exposure hist	tory with current info	rmation.

Family History

Yes	No	
		Are you 34 years or older?
		Is the father of your baby 55 years or older?
		Are you and the father of your baby blood relatives?
		Have you had a stillbirth or more than one miscarriage?
		Do you have diabetes? Are you insulin dependent?
		Do you have seizures or epilepsy?
		Do you have any other medical conditions for which you receive treatment?
		What countries are your ancestors from originally? (Be specific, e.g., England, Africa, Vietnam)
		Are either of you Jewish or French Canadian?
		Do you or the father of your baby
		Have any birth defects, handicapping condition or disorder that might be hereditary?
		Have any previous children with birth defects, handicaps or genetic conditions?
		Have any children who died (other than accidental)?
		Have any family members who have had multiple miscarriages or a stillbirth?

Environmental Exposure History

Yes	No	Have You			
		Taken any prescription drugs or over-the-counter medications since becoming pregnant? Please list each one:			
		Had an illness or infection during pregnancy?			
		Had a fever over 101 degrees or taken sauna / whirlpool baths during pregancy?			
		Had x-rays or surgery since becoming pregnant?			
		Had alcohol during your pregancy? How much?			
		Smoked cigarettes during your pregnancy? How many?			
		Used any drugs during your pregnancy?			

Please check any of the following that might be in either of your families. Please indicate who in the family is affected.

Anencephaly (open skull)	Mental Illness
Anemia	Mental Retardation
Blindness	Muscular Dystrophy / Myotonic Dystrophy
Cancer	Neurofibromatosis
Chromosome Abnormally	Neurologic or Degenerative Disorder
Cleft Lip / Palate	Phenylketonuria (PKU)
Cystic Fibrosis	Sickle Cell Anemia
Deafness	Skeletal Problems (like easily broken bones,
Down Syndrome	dwarfism)
Epilepsy or Seizures	Skin Disease (including dark or light patches
Heart Defect	of skin)
Hemophilia (bleeding tendency)	Spina Bifida
Huntington Disease	Thalessemia (Mediterranean Anemia)
Hydrocephalus (water on the brain)	Urinary Tract Disease
Kidney Disease (i.e. Polycystic kidney)	Birth Defects not listed above
Limb Defects	Other Genetic Condition

Delivery Date	Miscarriage	Termination	Weeks @ Delivery	Delivery Method (Vaginal/CSection)	Male/ Female	Infant Weight	Complications