

Comprehensive Women's Healthcare, P.A.

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NAME: _____

DOB: ____/____/____

New OB Questionnaire

Do you or anyone in your family have any of the following:

YES NO

- | | | |
|-------|-------|--|
| _____ | _____ | 0. Will you be 35 or older when you deliver |
| _____ | _____ | 1. Thalassemia (Italian, Greek Mediterranean, or Asian background) |
| _____ | _____ | 2. Neural Tube Defect (Meningocele, Spina bifida, or Anencephaly) |
| _____ | _____ | 3. Congenital Heart Defect |
| _____ | _____ | 4. Down Syndrome |
| _____ | _____ | 5. Tay-Sach (Ashkenazi Jewish, Cajun, French-Canadian) |
| _____ | _____ | 6. Canavan Disease (Ashkenazi Jewish) |
| _____ | _____ | 7. Familial Dysautonomia (Ashkenazi Jewish) |
| _____ | _____ | 8. Sickle Cell Disease or Trait (African) |
| _____ | _____ | 9. Hemophilia or other blood disorder |
| _____ | _____ | 10. Muscular Dystrophy |
| _____ | _____ | 11. Cystic Fibrosis |
| _____ | _____ | 12. Huntington's Chorea |
| _____ | _____ | 13. Mental Retardation/Autism |
| _____ | _____ | 14. If Yes, Was Person treated for Fragile X? |
| _____ | _____ | 15. Other inherited genetic or Chromosomal disorder: _____ |
| <hr/> | | |
| _____ | _____ | 16. Maternal Metabolic Disorder (e.g. Type 1 Diabetes, PKU) |
| _____ | _____ | 17. Patient or Baby's Father had a child with a birth defect not listed above? |
| _____ | _____ | 18. Recurrent Pregnancy loss, or a Stillbirth |
| _____ | _____ | 19. Live with someone with TB or exposed to TB |
| _____ | _____ | 20. Patient or partner has history of genital herpes |
| _____ | _____ | 21. Rash or viral illness since last menstrual period |
| _____ | _____ | 22. Hepatitis B or C |
| _____ | _____ | 23. History of STD, Gonorrhea, Chlamydia, HPV, HIV, or Syphilis |