Family History

Have your parents, siblings or children had the following:

	Yes	No	Relation
Breast Cancer	_____	_____	_____
Colon Cancer	_____	_____	_____
Ovarian Cancer	_____	_____	_____
Uterine Cancer	_____	_____	_____
Recurrent miscarriage	_____	_____	_____
Infertility	_____	_____	_____
Diabetes	_____	_____	_____
Endometriosis	_____	_____	_____
Fibroids	_____	_____	_____
Heart Disease	_____	_____	_____
Kidney Disease	_____	_____	_____
Depression	_____	_____	_____
Other (Please explain)	_____	_____	_____

Past Medical History

	Yes	No	Year/Description
Epilepsy/Seizures	_____	_____	_____
Other Neurological Disorders	_____	_____	_____
Tuberculosis	_____	_____	_____
Anemia	_____	_____	_____
Sickle Cell	_____	_____	_____
Heart Disease	_____	_____	_____
Clots in Legs/Lungs	_____	_____	_____
Kidney Disease	_____	_____	_____
Headaches/Migraines	_____	_____	_____
Thyroid Disorder	_____	_____	_____
High Blood Pressure	_____	_____	_____
Arthritis	_____	_____	_____
Autoimmune Disorder (Lupus)	_____	_____	_____
Depression/Postpartum Depression	_____	_____	_____
Asthma	_____	_____	_____
Diabetes	_____	_____	_____
Recurrent Urinary Tract Infections	_____	_____	_____
Hepatitis/Liver Disease	_____	_____	_____
Herpes	_____	_____	_____
Ulcers/Bowel Disease	_____	_____	_____
History of blood transfusion	_____	_____	_____
Rh (D) Sensitized	_____	_____	_____
Seasonal Allergies	_____	_____	_____
Breast Cancer	_____	_____	_____
HIV	_____	_____	_____
Chicken Pox	_____	_____	_____

Are your immunizations up-to-date? Date of last tetanus _____

Family Planning

Please check any method of contraceptive you have used in the past:

□ Birth Control Pills □ Condoms □ Depo-Provera/other injectable

□ IUD (Intrauterine Device) □ Diaphragm □ Withdrawal □ Spermicide

□ Patch □ Vaginal Ring □ Tubal Ligation □ Vasectomy

□ None □ Other

(Describe:_____)

Please check any method of Natural Family Planning you have used in the past:

□ None

□ Sympto-thermal (please circle: CCL Northwest Family Services)

□ Ovulation Method (please circle: Billings FAF Creighton)

□ Calendar/Rhythm

Which method do you currently use?

_____

Review of Systems

General
☐ Fatigue
☐ Weight gain
☐ Weight loss
☐ Fever
☐ Hot flashes

Endocrine
☐ Sensitivity to hot
☐ Sensitivity to cold
☐ Excessive thirst
☐ Abnormal hair growth
☐ Hair loss

Neuro
☐ Headaches
☐ Seizures
☐ Loss of strength
☐ Loss of sensation

Skin
☐ Rash
☐ Moles (growth/change)
☐ Acne

Eyes
☐ Visual changes
☐ Seeing spots or lights

ENT
☐ Sore throats
☐ Nasal congestion

Respiratory
☐ Cough
☐ Difficulty breathing

Heart
☐ Chest pain
☐ Palpitations

Breasts
☐ Breastfeeding
☐ Mass or lump
☐ Nipple discharge
☐ Breast tenderness
☐ Perform self-breast
☐ Other

Gastrointestinal
☐ Abnormal pain
☐ Nausea
☐ Vomiting
☐ Diarrhea
☐ Constipation
☐ Heartburn
☐ Blood in stool

GYN
☐ Vaginal discharge
☐ Vaginal burning/pain
☐ Vaginal bulge
☐ Vaginal /vulvar itching
☐ Pelvic pain/pressure
☐ Abnormal bleeding
☐ Other_____

Urology
☐ Painful /burning urination
☐ Blood in urine
☐ Leakage or loss of urine

Musculoskeletal
☐ Muscle pain
☐ Joint pain

Mood
☐ Depressed
☐ Anxiety
☐ Mood swings

Hematology
☐ Easy bruising
☐ Frequent nosebleeds

I verify that the information I have provided is accurate to the best of my knowledge.

_____ _____

Patient Signature Date

FAMILY HISTORY & GENETIC HISTORY

[Note: Please mark your answers carefully. The first column usually indicates family history negative for the genetic problem, while the second column indicates an area of possible concern to be discussed with the doctor.]

Circle one

1. Have either you or the baby's father had a child born with a birth defect? **Yes** **No**
   If Yes, please describe: _____
2. Did either you or the baby's father have a birth defect yourselves? **Yes** **No**
   If yes, please describe: _____
3. Please describe any abnormalities that have occurred in children in your family or the baby's father's family (i.e. mental retardation, birth defects, deformities, or inherited disease like hemophilia, muscular dystrophy, or cystic fibrosis.) _____
   _____
   _____
   How is the effected child/person related to you?_____
4. Do either you or the baby's father have a history of pregnancy losses (miscarriages or stillborn)? **Yes** **No**
   If Yes, have either of you had genetic counseling? **Yes** **No**
   If Yes, have either of you had chromosomal studies? **Yes** **No**
   If Yes, where and results?_____
5. Some genetic problems occur more in couples with certain racial or ancestral backgrounds. Please circle if either you or the baby's father is of one of these backgrounds:
   Jewish ancestry? **Yes** **No** If Yes, have you had Tay-Sachs screening tests? **Yes** **No**
   Date: ____ /____ /____ Result: _____
   Black? **Yes** **No** If Yes, have you had Sickle Cell screening? **Yes** **No**
   Date: ____ /____ /____ Result: _____
6. Please indicate if anyone in your family or the baby's father's family has:
   Diabetes **Yes** **No** If yes, how is that person related to you? _____
   Bleeding Disorder **Yes** **No** If yes, how is that person related to you? _____
   Hypertension **Yes** **No** If yes, how is that person related to you? _____
   Cancer **Yes** **No** If yes, how is that person related to you? _____
7. Please list any other concerns you have about birth defects or inherited disorders:
   _____
   _____
8. Will you be 35 or older at the time the baby is born: **Yes** **No**
9. Will the father be 50 or older? **Yes** **No**

_____ _____ _____ / _____ / _____
Patient Name (Print) Patient Signature Date

PHYSICIAN NOTES ON GENETIC HISTORY:

_____
_____
_____
_____
_____
_____