

Demographic Information		Mother of Baby	Father of Baby
	Name:		
Hospital for Delivery:	Age & Race:		
Pediatrician:	Language:		
Marital Status:	Religion:		
Phone:	Occupation:		

	Birth Year	Place of Birth	Sex	Birth Weight	Gestational Age	Delivery Type	Anesthesia Type	Length of Labor	Comments and/or Complications
1									
2									
3									
4									
5									
6									
7									
8									

Pregnancy History			
Total pregnancies:	Full term:	Premature:	Abortions:
Miscarriages:	Ectopics:	Multiple births:	Living:

Medical Risk Factors	Yes	No	Genetic Risk Factors	Yes	No
Seizure Disorder:	<input type="checkbox"/>	<input type="checkbox"/>	Drug, med, radiation exposure 1st trim:	<input type="checkbox"/>	<input type="checkbox"/>
Stroke:	<input type="checkbox"/>	<input type="checkbox"/>	Family history of birth defects:	<input type="checkbox"/>	<input type="checkbox"/>
Thyroid Disease:	<input type="checkbox"/>	<input type="checkbox"/>	Previous fetus/infant with birth defects:	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes:	<input type="checkbox"/>	<input type="checkbox"/>	Age greater than 35 at time of delivery:	<input type="checkbox"/>	<input type="checkbox"/>
Cardiac Disease:	<input type="checkbox"/>	<input type="checkbox"/>	Tay-Sachs:	<input type="checkbox"/>	<input type="checkbox"/>
Hypertension:	<input type="checkbox"/>	<input type="checkbox"/>	Sickle Cell Disease / Trait:	<input type="checkbox"/>	<input type="checkbox"/>
Lung Disease:	<input type="checkbox"/>	<input type="checkbox"/>	Thalassemia:	<input type="checkbox"/>	<input type="checkbox"/>
Gastrointestinal Disease:	<input type="checkbox"/>	<input type="checkbox"/>	Huntington Chorea:	<input type="checkbox"/>	<input type="checkbox"/>
Surgeries:	<input type="checkbox"/>	<input type="checkbox"/>	Cystic Fibrosis:	<input type="checkbox"/>	<input type="checkbox"/>
Liver Disease:	<input type="checkbox"/>	<input type="checkbox"/>	Muscular Dystrophy:	<input type="checkbox"/>	<input type="checkbox"/>
Renal Disease:	<input type="checkbox"/>	<input type="checkbox"/>	Hemophilia:	<input type="checkbox"/>	<input type="checkbox"/>
Venous Thromb/Pulmonary Embolism:	<input type="checkbox"/>	<input type="checkbox"/>	Spina Bifida / Anencephaly:	<input type="checkbox"/>	<input type="checkbox"/>
Blood Disease / Transfusions:	<input type="checkbox"/>	<input type="checkbox"/>	Down's Syndrome:	<input type="checkbox"/>	<input type="checkbox"/>
Cancer:	<input type="checkbox"/>	<input type="checkbox"/>	Hydroencephaly:	<input type="checkbox"/>	<input type="checkbox"/>
Organ Transplant:	<input type="checkbox"/>	<input type="checkbox"/>	Other:	<input type="checkbox"/>	<input type="checkbox"/>
Psychiatric:	<input type="checkbox"/>	<input type="checkbox"/>	<b>Allergies:</b>	<b>Medications:</b> (Name, Strength, & Dosage)	
HIV:	<input type="checkbox"/>	<input type="checkbox"/>			
Have you ever had an abnormal pap:	<input type="checkbox"/>	<input type="checkbox"/>			

Obstetric Risk Factors	Yes	No	Risk Factors for Preterm Birth	Yes	No
Previous stillbirth / neonatal death:	<input type="checkbox"/>	<input type="checkbox"/>	Age less than 18 or greater than 35:	<input type="checkbox"/>	<input type="checkbox"/>
Previous infant admitted to NICU:	<input type="checkbox"/>	<input type="checkbox"/>	Black race:	<input type="checkbox"/>	<input type="checkbox"/>
Previous infant with IUGR:	<input type="checkbox"/>	<input type="checkbox"/>	Weight less than 121 lbs (or 55 kg):	<input type="checkbox"/>	<input type="checkbox"/>
Abruption in prior pregnancy:	<input type="checkbox"/>	<input type="checkbox"/>	Previous uterine surgery:	<input type="checkbox"/>	<input type="checkbox"/>
Previous cesarean section:	<input type="checkbox"/>	<input type="checkbox"/>	Known uterine malformation:	<input type="checkbox"/>	<input type="checkbox"/>
Previous infant greater than 9 lbs:	<input type="checkbox"/>	<input type="checkbox"/>	Prior preterm birth ( 37 weeks or less):	<input type="checkbox"/>	<input type="checkbox"/>
History of fetal distress in labor:	<input type="checkbox"/>	<input type="checkbox"/>	Incompetent cervix:	<input type="checkbox"/>	<input type="checkbox"/>
History of Preeclampsia:	<input type="checkbox"/>	<input type="checkbox"/>	DES exposure:	<input type="checkbox"/>	<input type="checkbox"/>
History of Poly / Oligohadramnios:	<input type="checkbox"/>	<input type="checkbox"/>	2 or more miscarriages requiring D&C:	<input type="checkbox"/>	<input type="checkbox"/>
History of recurrent UTI:	<input type="checkbox"/>	<input type="checkbox"/>	Drug abuse (including alcohol):	<input type="checkbox"/>	<input type="checkbox"/>
Antibody sensitization:	<input type="checkbox"/>	<input type="checkbox"/>	Smoking:	<input type="checkbox"/>	<input type="checkbox"/>
Multiple gestation:	<input type="checkbox"/>	<input type="checkbox"/>	Psychosocial / physical abuse:	<input type="checkbox"/>	<input type="checkbox"/>
Other:	<input type="checkbox"/>	<input type="checkbox"/>	Have you ever had an STD:	<input type="checkbox"/>	<input type="checkbox"/>

**Comments:**