ADVANCED WOMEN'S OBGYN ASSOCIATES
PRENATAL RISK SCREENING

Name: ______________________________ Date: ______________

Please complete the following questionnaire to the best of your ability. These questions are designed in order to provide you with the best obstetrical care possible.

If you are currently experiencing or have a history of the following, please check the appropriate box:

1. Preterm birth or preterm labor ☐ Yes ☐ No
2. Current pregnancy with twins or more ☐ Yes ☐ No
3. DES exposure (medicine taken by your mother while she was pregnant with you) ☐ Yes ☐ No
4. Cone biopsy of your cervix ☐ Yes ☐ No
5. Two or more miscarriages or abortions ☐ Yes ☐ No
6. An abnormally shaped uterus or uterine surgery ☐ Yes ☐ No
7. Abdominal surgery during this pregnancy ☐ Yes ☐ No
8. Evaluation or treatment for an incompetent cervix ☐ Yes ☐ No
9. Too much or too little amniotic fluid ☐ Yes ☐ No
10. Recurrent urinary tract infections or kidney problems ☐ Yes ☐ No
11. Vaginal bleeding ☐ Yes ☐ No
12. Was your pre-pregnancy weight less than 115lbs or greater than 175lbs? ☐ Yes ☐ No
13. Excluding iron and vitamins, have you taken any medications (including non-prescription drugs) or recreational drugs since being pregnant or since your last menstrual period? ☐ Yes ☐ No

    If yes, give name of medication/drugs and time taken during pregnancy: ______________

    ____

    ____
14. Have you consumed alcoholic beverages since being pregnant? ☐ Yes ☐ No

    If yes, describe how often and amount: ______________________________
15. Do you have a history of glucose intolerance or diabetes in a past pregnancy? ☐ Yes ☐ No
16. Do you have any cats living in the house? ☐ Yes ☐ No
17. Have you or your partner ever had herpes, Chlamydia, or vaginal warts? ☐ Yes ☐ No
18. Have you ever been tested to determine if you are immune to rubella? ☐ Yes ☐ No

    If yes, please indicate where and when tested and the results of the test: ______________

List any questions for your physician that you would like addressed today:

1. ______________________________
2. ______________________________
3. ______________________________

☐ I have no questions or concerns today.

Patient signature: ______________________________ Date: ______________

FD 05 MD 02 ________ NEW OB

Form# TOP_PreRiskScreen

ADVANCED WOMEN'S OBGYN ASSOCIATES
PRENATAL GENETIC SCREENING

Name: ______________________________ Date: __________

1. Will you be 35 years or older when the baby is due? ☐ Yes ☐ No
2. Will the baby's father be 50 years or older when the baby is due? ☐ Yes ☐ No
3. Have you, the baby's father, or anyone in either of your families ever had any of the following disorders?
   - Down syndrome ☐ Yes ☐ No
   - Neural tube defect, i.e., spina bifida, (meningomyelocele or open spine), anencephaly ☐ Yes ☐ No
   - Hemophilia ☐ Yes ☐ No
   - Muscular dystrophy ☐ Yes ☐ No
   - Cystic fibrosis ☐ Yes ☐ No
   - Huntington's chorea ☐ Yes ☐ No

   If yes to any of the above, indicate the relationship of the affected person to you or to your baby's father:

   ____
4. Do you, the baby's father, or a close relative in either of your families have a birth defect, any familiar disorder, or a genetic abnormality not listed above? ☐ Yes ☐ No

   If yes, what was the defect and who had it? ______________________________
5. Do you or the baby's father have any close relatives with mental retardation, autism or developmental delay? ☐ Yes ☐ No

   If yes, indicate the relationship of the affected person to you or to your baby's father: ______________

   Indicate the cause, if known: ______________________________
6. Do you or the baby's father have any female relatives who experienced menopausal symptoms before age 40? ☐ Yes ☐ No

   If yes, indicate the relationship of the affected person to you or to your baby's father: ______________
7. Do you or the baby's father have any close relatives who have been diagnosed with a neurodegenerative disease called Spinal Muscular Atrophy? ☐ Yes ☐ No
8. In any previous pregnancies, have you or the baby's father had a stillborn child, or 3 or more first trimester spontaneous pregnancy losses? ☐ Yes ☐ No
9. Have either you or the baby's father ever had a chromosomal study? ☐ Yes ☐ No

   If yes, indicate who and the results: ______________________________
10. Are you or the baby's father of the Eastern European Jewish, French Canadian or Cajun ancestry? ☐ Yes ☐ No

    If so, have either of you been screened for Tay-Sachs disease? ☐ Yes ☐ No

    If yes, indicate who and the results: ______________________________
11. Are you or the baby's are of Italian, Greek, or Mediterranean ancestry? ☐ Yes ☐ No

    If so, have either of you been screened for B-thalassemia? ☐ Yes ☐ No

    If yes, indicate who and the results: ______________________________
12. Are you or the baby's father are of African or Hispanic ancestry? ☐ Yes ☐ No

    If so, have either of you been screened for sickle cell trait? ☐ Yes ☐ No

    If yes, indicate who and the results: ______________________________
13. If you or the baby's father are of Philippine or Southeast Asian ancestry, have either of you been screened for A-thalassemia?

    ☐ Yes ☐ No

    If yes, indicate who and the results: ______________________________

FD 06 MD 03 ________ NEW OB