



Affix Patient Label

Patient Name:

DOB:

Bronson OB/GYN Associates - Obstetric History and Genetic Screening

A birth defect is a physical problem that a baby has at birth. Most babies, 97%, are born without major birth defects. Genetic disorders may be caused by problems with genes or chromosomes. Some disorders are inherited and some occur at random.

Are there any birth defects (spina bifida, cleft palate/lip, etc) in either family? Yes No
(Family includes you, father of the baby, siblings, close relatives)

If yes, please describe:

Are there any genetic defects (Cystic Fibrosis, Muscular Dystrophy, etc) in either family? Yes No
If yes, please describe:

Do you belong to any of these racial or ethnic backgrounds?

Eastern European Ashkenazi Jewish Asian Mediterranean/Greek

African American --- Have you been tested for Sickle Cell Anemia? Yes No

Were you exposed to medications, drugs, or alcohol before you were aware that you were pregnant? Yes No
If yes, please indicate type and amount: _____

Are you currently taking any medications? Please include and over the counter, prescription, herbal supplements, vitamins, inhalers, etc.

Medication	Dose	Frequency	Prescribed By

Patient Signature

Date

Reviewed by

Date

Please take a few minutes to complete the following questions. It will help us stay current on very important health issues affecting you, and allow the most efficient use of time with the Doctor.

Thank you!

Birth Control

What type of birth control (if any) are you currently using? _____

When are you planning your next child?

Within the next year Within the next 5 years Within the next 10 years My family is complete

Would you like information on a permanent birth control procedure performed in the comfort of our office?

Yes No

Menstrual Periods

How long does your average monthly period last? _____ Days

Do your periods ever impact the quality of your life? Yes No

Do you ever have irregular or inconsistent bleeding or spotting? Yes No

Would you like information on a procedure performed in our office that can significantly reduce or eliminate your monthly periods? Yes No

Urinary Health

Do you ever leak urine when you cough, laugh or sneeze? Yes No

Do you ever feel as though you have to urinate urgently? Yes No

Do you feel like you have to urinate too frequently? Yes No

Do you ever experience painful urination? Yes No

Is there anything else you would like to discuss with the doctor? _____
