**MidMichigan Obstetrics & Gynecology \* 3016 W. Wackerly St. \* Midland, MI 48640 \* T 989-631-6730 / F 989-631-4968**

**PRENATAL DIAGNOSIS SCREENING EVALUATION**

**Patient**

Name DOB Date

**Significant Other**

Name DOB Occupation

**Father of Baby (IF DIFFERENT THAN SIGNIFICANT OTHER)**

Name DOB Occupation

**Physicians**

OB Pediatrician

Does your family or the biological father of the baby’s family have the following ethnic background:

Yes □ No □ Southeast Asia, Taiwan, China, or the Philippines

Yes □ No □ Italy, Greece, or the Middle East

Yes □ No □ Eastern European (Ashkenazi) Jewish

Yes □ No □ French Canadian

Yes □ No □ African American, African, or Black

Have you or your partner been tested for thalassemia? Yes □ No □

Have you or your partner been tested for Tay Sachs? Yes □ No □

Have you or your partner been tested for sickle cell anemia? Yes □ No □

Have you, the baby’s biological father, or anyone in either of your families ever had any of the following?

Yes □ No □ Down Syndrome

Yes □ No □ Neural Tube Defect (e.g. spina bifida, anencephaly)

Yes □ No □ Hemophilia or Other Bleeding Disorders

Yes □ No □ Muscular Dystrophy

Yes □ No □ Cystic Fibrosis

Yes □ No □ Huntington’s Disease

Yes □ No □ Heart Defect (from birth)

Yes □ No □ Do you or the baby’s father have any relatives with mental retardation or developmental delay?

Yes □ No □ Does anyone in either of your families have a genetic defect, or chromosome abnormality not listed?

If “yes”, please explain:

Yes □ No □ Have you or the baby’s biological father had a stillborn child, or three or more first trimester miscarriages?

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3016 W. Wackerly Street

Midland, MI 48640

Phone 989-631-6730 Fax 989-631-4968

**Date:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**Legal Name:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **DOB:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Maiden Name:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Preferred Name:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

*Please circle:*

**Birth Sex:** Female Male

**Identifies as:** Female F-to-M Transgender Male M-to-F Transgender Non-conforming Gender Other

**Medical Sex:** Female Male

**Preferred Pronoun Sex:** Female Gender Neutral Male

**Administrative Sex:** Female Male

**Sexual Orientation:** Asexual Bisexual Gay Heterosexual Lesbian Other

**Relationship status:** Single Married Divorced Widowed Separated Partner

**Race:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Ethnicity:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Language:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Occupation:** **Employer:**

**REASON FOR VISIT** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**PRIMARY CARE PHYSICIAN**

**Please list any changes since your last visit:**

New allergies: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

New surgeries: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

New medical problems: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

New family history: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Current Medications (name, dosage, frequency):**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**Preferred Pharmacy:** **Location:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**MENSTRUAL HISTORY**

First date of Last Menstrual Period \_\_\_\_\_\_\_\_\_\_\_\_\_ Age periods began: \_\_\_\_\_ Contraception \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Periods occur every \_\_\_\_\_days, and last for \_\_\_\_\_\_\_ days. Flow is: Light / Moderate / Heavy? Clots? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please describe any irregularities: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**SOCIAL HISTORY**

Alcohol Never \_\_\_\_\_Occasional \_\_\_\_\_Moderate \_\_\_\_\_Daily

Tobacco \_ Never \_\_\_\_\_Occasional \_\_\_\_\_Moderate \_\_\_\_\_Daily

Illicit Drugs No Yes Type/Frequency\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

History of, or current physical or sexual abuse ­­­­­­­­­\_\_\_\_\_No \_\_\_\_\_\_Yes

PATIENT NAME: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DATE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**PATIENT INFORMATION FORM SYSTEM REVIEW**

(MD NOTE: Ext ROS= > 2 systems, Complete ROS = > 10 systems = pert positive + all others ‘negative’)

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **GENERAL** | NO | YES | **GASTROINTESTINAL CONT.** | NO | YES |
| Appetite loss |  |  | Hemorrhoids |  |  |
| Chills |  |  | Heartburn |  |  |
| Fatigue |  |  | Incontinence of Stool |  |  |
| Fever |  |  | **FEMALE GENITOURINARY** |  |  |
| Night Sweats |  |  | Absence of Menstruation |  |  |
| Weight gain |  |  | Blood in Urine |  |  |
| Weight loss |  |  | Dysmenorrhea (Painful) |  |  |
| **SKIN** |  |  | Frequency (Urinating) |  |  |
| Bruising |  |  | Menorrhagia (Heavy) |  |  |
| Dryness |  |  | Menstrual Irregularities |  |  |
| Hair Growth |  |  | Painful Intercourse |  |  |
| Hair Loss |  |  | Painful Urination |  |  |
| New Lesions |  |  | Pelvic Pain |  |  |
| **HEENT** |  |  | Vaginal Discharge |  |  |
| Wear contacts/glasses |  |  | Vaginal Dryness |  |  |
| Hearing loss |  |  | Vaginal itching/burning |  |  |
| Nose bleeds |  |  | Decreased libido |  |  |
| Dental problems |  |  | Hot flashes |  |  |
| **NECK** |  |  | Sexual difficulty |  |  |
| Neck pain |  |  | Vulvar lesion |  |  |
| Neck Stiffness |  |  | Urine leakage |  |  |
| Swollen glands |  |  | **MUSCULOSKELETAL** |  |  |
| **RESPIRATORY** |  |  | Back Pain |  |  |
| Cough |  |  | Joint Pain |  |  |
| Difficulty Breathing |  |  | Muscle Cramps |  |  |
| Snoring |  |  | Muscle Pain |  |  |
| Shortness of Breath |  |  | Varicose Veins |  |  |
| **BREAST** |  |  | **NEUROLOGICAL** |  |  |
| Breast mass |  |  | Dizziness |  |  |
| Breast pain |  |  | Headaches |  |  |
| Nipple discharge |  |  | Visual Changes |  |  |
| Skin changes |  |  | **PSYCHIATRIC** |  |  |
| Breast cysts |  |  | Anxiety |  |  |
| **CARDIOVASCULAR** |  |  | Depression |  |  |
| Chest pain |  |  | Frequent crying |  |  |
| Elevated Blood Pressure |  |  | Inability to concentrate |  |  |
| Fainting/Blacking Out |  |  | Insomnia |  |  |
| Murmur |  |  | Memory loss |  |  |
| Rapid Heart Rate |  |  | **ENDOCRINE** |  |  |
| Slow Heart Rate |  |  | Cold Intolerance |  |  |
| **GASTROINTESTINAL** |  |  | Excessive Thirst |  |  |
| Abdominal Pain |  |  | **HEMATOLOGY** |  |  |
| Bloating |  |  | Anemia |  |  |
| Change in Bowel Habits |  |  | Blood Clots |  |  |
| Constipation |  |  | Past Transfusions |  |  |
| Diarrhea |  |  |  |  |  |

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