

MORRIS AHDOOT, M.D.

GENERAL

- YES NO WILL YOU BE 35 YEARS WHEN YOU DELIVER?
- YES NO WILL YOU BE 39 YEARS OLD OR OLDER WHEN YOU DELIVER?
- YES NO WILL YOU BE UNDER 18 YEARS OF AGE AT DELIVERY?
- YES NO ARE YOU ALLERGIC TO ANY MEDICATIONS?
- YES NO HAVE YOU EVER HAD A BABY WITH RH DISEASE OR RELATED PROBLEMS?
- YES NO ARE YOU PREGNANT WITH TRIPLETS (OR MORE) ?
- YES NO ARE PREGNANT WITH TWINS?
- YES NO HAVE YOU HAD A CHILD DIE AT AN EARLY AGE ?

FAMILY/GENETIC HISTORY

- YES NO DOES ANYONE IN YOUR FAMILY HAVE CYSTIC FIBROSIS? BABY'S FATHER'S FAMILY?
- YES NO DOES ANYONE IN YOUR FAMILY HAVE DOWN'S SYNDROME OR OTHER GENETIC ABNORMALITIES? BABY'S FATHER'S FAMILY?
- YES NO DOES ANYONE IN YOUR FAMILY HAVE A BLEEDING PROBLEM-HEMOPHILIA? BABY'S FATHERS FAMILY?
- YES NO IS ANYONE IN YOUR FAMILY CONSIDERED "SLOW" OR HAVE AN UNEXPLAINED CONDITION OF MENTAL RETARDATION? BABY'S FATHER'S FAMILY?
- YES NO DOES ANYONE IN YOUR FAMILY HAVE MUSCULAR DYSTROPHY? BABY'S FATHER'S FAMILY?
- YES NO DOES ANYONE IN YOUR FAMILY HAVE PHENYLKETONURIA(PKU)? BABY'S FATHER'S FAMILY?
- YES NO DOES ANYONE IN YOUR FAMILY HAVE NEURAL TUBE DEFECT?(MENINGOMYELOCELE OPEN SPINE, OR ANECEPHALY)? BABY'S FATHER'S FAMILY?
- YES NO DOES ANYONE IN YOUR FAMILY HAVE HUNTINGTON'S CHOREA? BABY'S FATHER'S FAMILY?
- YES NO DOES ANYONE IN YOUR FAMILY HAVE A SERIOUS GENETIC PROBLEM? BABY'S FATHER'S FAMILY?
- YES NO ARE YOU OR THE BABY'S FATHER JEWISH OR OF FRENCH CANADIAN HERITAGE?
- YES NO ARE YOU OR THE BABY'S FATHER OF MEDITERRANEAN OR ASIAN HERITAGE?
- YES NO DO YOU OR THE BABY'S FATHER HAVE SICKLE CELL ANEMIA OR THALASSEMIA?
- YES NO HAVE YOU EVER BEEN PREGNANT WITH A BABY WHICH HAD SIGNIFICANT BIRTH DEFECTS OR GENETIC ABNORMALITIES?
- YES NO WERE YOU ON PRESCRIPTION MEDICATIONS OR OVER THE COUNTER MEDICATIONS WHEN YOU GOT PREGNANT? PLEASE LIST:
- YES NO HAVE YOU HAD AN X-RAY OR RADIOACTIVE MEDICATIONS SINCE YOUR LAST MENSTRUAL PERIOD?
- YES NO HAVE YOU BEEN EXPOSED TO ANY HARMFUL CHEMICALS DURING THE PREGNANCY? PLEASE LIST:

PAST OBSTETRICAL/GYNECOLOGIC

- YES NO HAVE YOU EVER BEEN TOLD YOU HAVE AN ABNORMALLY FORMED UTERUS?
- YES NO HAVE YOU EVER LOST A PREGNANCY AT 15 TO 25 WEEKS?
- YES NO HAVE YOU EVER HAD THREE OR MORE SPONTANEOUS MISCARRIAGES?
- YES NO HAVE YOU EVER BEEN DIAGNOSED AS HAVING INCOMPETENT CERVIX OR HAD A CERCIAGE?
- YES NO HAVE YOU EVER BEEN TOLD YOU HAVE FIBROIDS?

INFECTION RISKS

- YES NO HAVE YOU EVER BEEN TREATED FOR SEXUALLY TRANSMITTED DISEASES?
- YES NO HAVE YOU OR YOUR PARTNER EVER BEEN DIAGNOSED WITH GENITAL HERPES?
- YES NO HAVE YOU BEEN TREATED FOR 3 OR MORE URINARY TRACT INFECTIONS?
- YES NO HAVE YOU EVER BEEN TOLD YOU ARE HIV POSITIVE?

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- YES NO HAVE YOU HAD FIFTH DISEASE (PARVOVIRUS) SINCE BEING PREGNANT?

YES NO DID YOU RECEIVE TRANSFUSION OF BLOOD PRIOR TO 1985?

YES NO HAVE YOU EVER BEEN DIAGNOSED WITH HEPATITIS B?

MEDICAL

YES NO HAVE YOU EVER HAD CANCER WHICH IS IN REMISSION?

YES NO ARE YOU CURRENTLY BEING TREATED FOR CANCER?

YES NO HAVE YOU EVER BEEN TOLD YOU HAVE HIGH BLOOD PRESSURE?

YES NO ARE YOU TAKING MEDICATIONS TO CONTROL HIGH BLOOD PRESSURE?

YES NO HAVE YOU BEEN TOLD YOU HAVE HIGH BLOOD PRESSURE FROM KIDNEY DISEASE?

YES NO DO YOU TAKE MEDICATIONS FOR ASTHMA? PLEASE LIST:

YES NO HAVE YOU EVER HAD ASTHMA? IF YES, HOW LONG AGO?

YES NO DID YOUR MOTHER TAKE DES WHILE CARRYING YOU?

YES NO HAVE YOU EVER TAKEN MEDICATIONS FOR A SEIZURE DISORDER?

YES NO ARE YOU TAKING MEDICATION AND STILL HAVING SEIZURES?

YES NO IN ADDITION TO KIDNEY DISEASE, DO YOU HAVE HYPERTENSION OR OTHER PROBLEMS?

YES NO HAVE YOU EVER BEEN EXPOSED TO HYPERTHYROIDISM?(NOT TO BE CONFUSED WITH HYPOT, OFTEN TREATED WITH SYNTHROID)

YES NO ARE YOU TAKING MEDICATIONS TO CONTROL HYPER THYROIDISM?(NOT SYNTHROID, A TREATMENT FOR HYPOTHYROIDISM)

YES NO ARE YOU INSULIN DEPENDENT TO CONTROL YOU DIABETES?

YES NO DO YOU HAVE DIABETES WITH HIGH BLOOD PRESSURE, KIDNEY PROBLEMS OR LUPUS?

YES NO HAVE YOU EVER BEEN DIAGNOSED WITH SYSTEMIC LUPUS ERYTHEMATOSIS?

YES NO HAVE YOU EVER TAKEN MEDICATIONS FOR LUPUS OR HAD COMPLICATIONS OF HIGH BLOOD PRESSURE OR KIDNEY DISEASE?

YES NO HAVE YOU EVER BEEN DIAGNOSED WITH MITRAL VALVE PROLAPSE?

YES NO HAVE YOU EVER BEEN TOLD YOU HAVE HEART PROBLEMS?

YES NO HAVE YOU EVER BEEN TOLD YOU HAVE TENDENCY TO FORM BLOOD CLOTS EASILY (BLOOD FACTOR)?

YES NO HAVE YOU EVER PROBLEMS WITH HEART DISEASE?

YES NO HAVE YOU EVER HAD A STROKE OR OTHER NEUROLOGIC PROBLEM?

YES NO DO YOU BRUISE EASILY OR HAVE YOU BEEN TOLD YOU HAVE LOW PLATELET COUNT?

YES NO HAVE YOU EVER SEEN A HEALTHCARE PROFESSIONAL FOR PSYCHIATRIC HELP?

YES NO HAVE YOU EVER SEEN A HEALTHCARE PROFESSIONAL FOR ANXIETY OR DEPRESSION?

YES NO HAVE YOU EVER BEEN TREATED FOR SERIOUS BLOOD CLOTS IN YOU LEGS OR LUNGS?

YES NO HAVE YOU HAD TREATMENT FOR BREATHING PROBLEMS; ASTHMA OR OTHER PROBLEMS?

YES NO HAVE YOU BEEN HOSPITALIZED FOR BREATHING PROBLEMS? PLEASE EXPLAIN:

OBSTETRICAL

YES NO HAVE YOU EVER HAD A DELIVERY BY CESAREAN SECTION?

YES NO IF YOU HAD PREVIOUS CESAREAN SECTION, DO YOU PLAN ON HAVING ANOTHER CESAREAN SECTION?

YES NO HAVE YOU EVER DELIVERED AN INFANT WEIGHING 9 POUNDS OR MORE?

YES NO HAVE YOU EVER HAD AN INFANT WEIGHING LESS THAN 5 POUNDS?

YES NO DURING ANY PREVIOUS PREGNANCY, DID YOU HAVE PLACENTAL ABRUPTION OR ANY OTHER BLEEDING?

YES NO WITH ANY PREVIOUS PREGNANCY, DID YOU EXPERIENCE HEMORRHAGE AFTER DELIVERY?

YES NO HAVE YOU EVER DELIVERED A STILLBORN CHILD?

YES NO HAVE YOU BEEN HOSPITALIZED OR TREATED FOR PREMATURE LABOR OR DELIVERED A PREMATURE BABY (36 WEEKS OR EARLIER)?

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YES NO HAVE YOU EVER HAD SURGERY ON YOUR UTERUS (FIBROID REMOVAL, SEPTUM REMOVAL, ECT.)?

YES NO HAVE YOU EVER HAD SURGERY ON YOUR CERVIX (CONIZATION, FREEZING, LEEP, ECT.)?

YES NO HAVE YOU EVER HAD A TUBAL PREGNANCY (ECTOPIC PREGNANCY)?

SOCIAL HABITS

- YES NO DO YOU DRINK SOCIALLY?
- YES NO DO YOU HAVE BULIMIA, ANOREXIA OR ANY OTHER SERIOUS EATING DISORDER?
- YES NO DO YOU EVER FEEL THREATENED BY PHYSICAL, EMOTIONAL OR VERBAL ABUSE?
- YES NO DO YOU SMOKE CIGARETTES?
- YES NO HAVE YOU EVER USED RECREATIONAL DRUGS?
- YES NO ARE YOU CURRENTLY USING RECREATIONAL DRUGS?
- YES NO HAVE YOU USED ANY OVER THE COUNTER MEDICATIONS SINCE BECOMING PREGNANT?

PLEASE PROVIDE:

FULL NAME _____

DATE OF BIRTH _____

SSN _____

DATE _____

PHYSICIAN _____