Date: _____ PERSONAL AND FAMILY HEALTH HISTORY

The purpose of this questionnaire is to identify any special needs you may have. Yours answers will remain confidential.

NAME _____ AGE _____ DATE OF BIRTH _____

ADDRESS _____

_____

MARITAL STATUS M____ S____ D____ W____

SOCIAL SECURITY # _____

GRADE COMPLETED_____

EMPLOYER _____

HOME PHONE: _____

CELL PHONE: _____

EMERGENCY CONTACT NAME_____

EMERGENCY CONTACT PHONE_____

EMPLOYER PHONE_____

LAST MENSTRUAL PERIOD_____

PLEASE INDICATE BELOW IF YOU OR ANY OF YOUR CLOSE BLOOD RELATIVES HAVE EXPERIENCED ANY OF THE FOLLOWING:

	YOU	FAMILY
High Blood Pressure		
Heart Trouble / Heart Attack		
Diabetes		
Brain Tumor		
Seizures		
Migraine Headaches		
Scoliosis		
Thyroid Problems		
Adrenal Gland Problems		
Pituitary Problems		
Cushing's Disease		
Bleeding Problems		
Chronic Anemia		
Sickle Cell Trait / Disease		

PLEASE INDICATE BELOW IF YOU HAVE EVER EXPERIENCED OR BEEN TOLD THAT YOU HAVE ANY OF THE FOLLOWING:

	YOU
Rheumatic Fever	
Scarlet Fever	
Asthma	
Bronchitis	
Pneumonia	
Hiatal Hernia	
Ulcers	
Gallbladder Problems / Stones	
Crohn's Disease	

	YOU	Husband
Irritable Bowel Syndrome		
Colitis		
Heart Murmur		
Phlebitis		
Varicose Veins		
Blood Clots in Legs or Lungs		
Hepatitis		
Jaundice		
Kidney Stones		
Kidney or Bladder Infection		
Lymphoma		
Other Cancer (Specify) _____		
Mononucleosis		
Encephalitis		
Measles		
Chicken Pox		
Gonorrhea		
Chlamydia		
Trichomoniasis		
Yeast Infections		
Herpes		
Genital Warts		

USUAL MENSTRUAL CYCLE: *LENGTH* _____
DURATION _____ *AMOUNT* _____

ANY IRREGULAR BLEEDING _____

DID YOU HAVE ANY PROBLEMS BECOMING PREGNANT _____

HAVE YOU EVER HAD AN OPERATION _____
YEAR _____ *PROCEDURE* _____
HOSPITAL _____ *PHYSICIAN* _____

HAVE YOU EVER BEEN HOSPITALIZED _____
YEAR _____ *DIAGNOSIS* _____

HAVE YOU EVER HAD ANY SERIOUS ACCIDENTS _____

ARE YOU ALLERGIC TO ANY MEDICINES (SPECIFY) _____

PATIENT NAME _____ SCREENING QUESTIONNAIRE DATE_____

	YES	NO
1. Will you be age 35 or older when you have children?	____	____
2. Have you or your partner or anyone in either of your families ever had:	____	____
Down's Syndrome	____	____
Spina Bifida or Meningomyelocele (open spine)	____	____
Hemophilia	____	____
Muscular Dystrophy	____	____
Cystic Fibrosis	____	____
3. Have you or your partner had a child born dead or alive with a birth defect not listed in question 2 above	____	____
If yes, describe		
_____		
4. Do you or your partner have any close relatives who are mentally retarded or have birth defects?	____	____
If yes, list cause if known		
_____		
5. Do you or your partner or a close relative in either of your families have any inherited genetic or chromosomal disease or disorder not listed above	____	____
If yes, describe		
_____		
6. Have you or your partner had 3 or more spontaneous pregnancy losses (miscarriages, stillbirths, etc.?)	____	____
7. Do you or your partner have any close relatives descended from Jewish people who lived in Eastern Europe (Ashkenazi Jews)?	____	____
If yes, have either you or your partner been screened for Tay-Sacha disease?	____	____
If yes, indicate results and who was screened		
_____		
8. Are you or your partner African American?	____	____
If yes, have either you or your partner, or any close relative ever been screened for sickle cell trait and found to be positive?	____	____
If yes, indicate results and who was screened		
_____		
9. Do you or your partner have any close relatives descended from Mediterranean countries?	____	____
If yes, have you, or your partner, been screened for thalassemia (Cooley's anemia)?	____	____
If yes, indicate results and who was screened:		
_____		
10. Do you drink alcoholic beverages?	____	____
If yes, describe how often and amount:		
_____		
11. Do you take any medications either by prescription or those which can be purchased over the counter in a drug store	____	____
If yes, please list drugs and dosage schedule:		
_____		
12. Have you ever been tested to determine if you are immune to rubella (German Measles)?	____	____
If yes, please indicate where and when tested and results of test:		

HAVE YOU EVER DONATED BLOOD_____

HAVE YOU EVER BEEN TESTED FOR HIV / AIDS_____

DO YOU SMOKE____ HOW MUCH BEFORE PREGNANCY_____
SINCE PREGNANCY _____

DO YOU DRINK BEER, WINE, OR HARD LIQUOR_____

DO YOU USE MARIJUANA_____COCAINE_____OTHER DRUGS_____

WHAT PRESCRIPTION OR OVER-THE-COUNTER MEDICATIONS DO YOU TAKE REGULARLY

_____

DO YOU OWN A CAT_____ DO YOU HANDLE THE KITTY LITTER_____

PREGNANCY HISTORY

NO	YEAR	SEX	WEIGHT	HOURS IN LABOR	PROBLEMS WITH PREGNANCY OR BIRTH (Indicate miscarriages or abortions here)
1					
2					
3					
4					
5					
6					
7					
8					