

**SYMPTOMSSINCELMP**

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|  | YES | NO |   | YES | NO |
|--|-----|----|---|-----|----|
| 1. PATIENT' SAGE (35 OR OLDER)   |     |    | 12. MENTAL RETARDATION/AUTISM   |     |    |
| 2. THALASSEMIA (ITALIAN, GREEK, MEDITERRANEAN, OR ASIAN BACKGROUND) MCV < 80 |     |    | IF YES, WAS PERSON TREATED FOR FRAGILE X?                                     |     |    |
| 3. NEURAL TUBE DEFECT (MENINGOCELE, SPINA BIFIDA, OR ANENCEPHALY)            |     |    | 13. OTHER INHERITED GENETIC OR CHROMOSOMAL DISORDER                           |     |    |
| 4. CONGENITAL HEART DEFECT   |     |    | 14. MATERNAL METABOLIC DISORDER (EG. INSULIN DEPENDENT DIABETES, PKU)         |     |    |
| 5. DOWNSYNDROME  |     |    | 15. PATIENT OR BABY' S FATHER HAD A CHILD WITH BIRTH DEFECTS NOT LISTED ABOVE |     |    |
| 6. TAY-SACHS (EG. JEWISH, CAJUN, FRENCH-CANADIAN)                            |     |    | 16. RECURRENT PREGNANCY LOSS, OR STILLBIRTH                                   |     |    |
| 7. SICKLE CELL DISEASE OR TRAIT (AFRICAN)                                    |     |    | 17. MEDICATIONS/STREET DRUGS/ALCOHOL SINCE LAST MENSTRUAL PERIOD              |     |    |
| 8. HEMOPHILIA  |     |    | IF YES, AGENT(S)  |     |    |
| 9. MUSCULAR DYSTROPHY  |     |    | 18. ANY OTHER   |     |    |
| 10. CYSTIC FIBROSIS  |     |    |   |     |    |
| 11. HUNTINGTON CHOREA  |     |    |   |     |    |

**COMMENTS/COUNSELING** \_\_\_\_\_

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| INFECTION HISTORY                                   | YES | NO |  | YES | NO |
|---|-----|----|--|-----|----|
| 1. HIGH RISK HEPATITIS B/IMMUNIZED?                 |     |    | 4. RASH OR VIRAL ILLNESS SINCE LAST MENSTRUAL PERIOD |     |    |
| 2. LIVE WITH SOMEONE WITH TB EXPOSED TO TB          |     |    | 5. HISTORY OF STD. GC. CHLAMYDIA HPV. SYPHILIS       |     |    |
| 3. PATIENT OR PARTNER HAS HISTORY OF GENITAL HERPES |     |    | 6. OTHER (SEE COMMENTS)                              |     |    |

**COMMENTS** \_\_\_\_\_

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**INTERVIEWER'S SIGNATURE** \_\_\_\_\_

| INITIAL PHYSICAL EXAMINATION |                                 |                                   |                         |                                 |                                   |
|------------------------------|---------------------------------|-----------------------------------|-------------------------|---------------------------------|-----------------------------------|
| DATE                         | PRE PREGNANCY WEIGHT            |                                   | HEIGHT                  | BP                              |                                   |
| 1. HEENT                     | <input type="checkbox"/> NORMAL | <input type="checkbox"/> ABNORMAL | 12. VULVA               | <input type="checkbox"/> NORMAL | <input type="checkbox"/> ABNORMAL |
| 2. FUNDI                     | <input type="checkbox"/> NORMAL | <input type="checkbox"/> ABNORMAL | 13. VAGINA              | <input type="checkbox"/> NORMAL | <input type="checkbox"/> ABNORMAL |
| 3. TEETH                     | <input type="checkbox"/> NORMAL | <input type="checkbox"/> ABNORMAL | 14. CERVIX              | <input type="checkbox"/> NORMAL | <input type="checkbox"/> ABNORMAL |
| 4. THYROID                   | <input type="checkbox"/> NORMAL | <input type="checkbox"/> ABNORMAL | 15. UTERUS SIZE         | <input type="checkbox"/> NORMAL | <input type="checkbox"/> ABNORMAL |
| 5. BREASTS                   | <input type="checkbox"/> NORMAL | <input type="checkbox"/> ABNORMAL | 16. ADNEXA              | <input type="checkbox"/> NORMAL | <input type="checkbox"/> ABNORMAL |
| 6. LUNGS                     | <input type="checkbox"/> NORMAL | <input type="checkbox"/> ABNORMAL | 17. RECTUM              | <input type="checkbox"/> NORMAL | <input type="checkbox"/> ABNORMAL |
| 7. HEART                     | <input type="checkbox"/> NORMAL | <input type="checkbox"/> ABNORMAL | 18. DIAGONAL CONJUGATE  | <input type="checkbox"/> NORMAL | <input type="checkbox"/> ABNORMAL |
| 8. ABDOMEN                   | <input type="checkbox"/> NORMAL | <input type="checkbox"/> ABNORMAL | 19. SPINES              | <input type="checkbox"/> NORMAL | <input type="checkbox"/> ABNORMAL |
| 9. EXTREMITIES               | <input type="checkbox"/> NORMAL | <input type="checkbox"/> ABNORMAL | 20. SACRUM              | <input type="checkbox"/> NORMAL | <input type="checkbox"/> ABNORMAL |
| 10. SKIN                     | <input type="checkbox"/> NORMAL | <input type="checkbox"/> ABNORMAL | 21. SUBPUBIC ARCH       | <input type="checkbox"/> NORMAL | <input type="checkbox"/> ABNORMAL |
| 11. LYMPH NODE               | <input type="checkbox"/> NORMAL | <input type="checkbox"/> ABNORMAL | 22. GYN ECO PELVIC TYPE | <input type="checkbox"/> NORMAL | <input type="checkbox"/> ABNORMAL |

**COMMENTS** (Number and explain abnormalities) \_\_\_\_\_

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**EXAM BY** \_\_\_\_\_