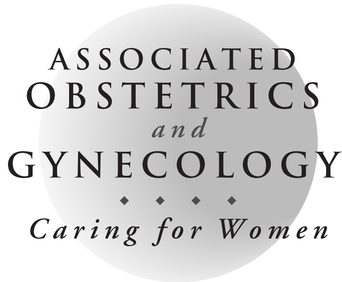

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Patricia Kondratenko, D.O.

OB Genetic History

Office Use Only

Patient # ________________ Date _________

Name ____ DOB ______________________

Note: This record is confidential. Information will not be released to anyone without your authorization.

Today's Date ______________________ Last Menstrual Period ______________________

Current Pregnancy

If you answer yes to any of the following questions, please explain on the space provided.

Have you taken any medication (prescription or over the counter) since becoming pregnant or since your last period? ❍ Yes ❍ No

____

Have you had any illness or infection during this pregnancy? ❍ Yes ❍ No

____

Have you had a fever over 101° or taken saunas or hot whirlpool baths during this pregnancy? ❍ Yes ❍ No

____

Have you had x-rays or surgery since becoming pregnant? ❍ Yes ❍ No

____

Have you been exposed to anesthetic gases,lead, or radiation in your occupation? ❍ Yes ❍ No

____

Have you consumed more than one glass of alcohol per week during this pregnancy? ❍ Yes ❍ No

____

Did you become pregnant while using birth control pills? ❍ Yes ❍ No

____

Patient Medical History

If you answer yes to any of the following questions, please explain on the space provided.

Do you have diabetes? ❍ Yes ❍ No

____

Do you have seizures or epilepsy? ❍ Yes ❍ No

____

Do you have kidney disease? ❍ Yes ❍ No

____

Do you or the baby's father have a history of treatment for cancer? ❍ Yes ❍ No

____

Name ____

Office Use Only
Patient # ______________ Date _________

Patient Medical History (Continued)

Will you be 35 years old or older at the time of delivery? ❍ Yes ❍ No

___

Will the baby's father be 35 years old or older at the time of delivery? ❍ Yes ❍ No

___

Is there any chance that you and the father could be blood relatives? ❍ Yes ❍ No

___

Are you or the father of Jewish, African American or Mediterranean descent? ❍ Yes ❍ No

___

Have you ever had a still birth? ❍ Yes ❍ No

___

Have you ever had a miscarriage? ❍ Yes ❍ No

___

Have you or the baby's father had birth defects, handicaps, or other conditions that could be hereditary? ❍ Yes ❍ No

___

Have you had other children with birth defects, handicaps or genetic diseases? ❍ Yes ❍ No

___

Do you have siblings or parents with birth defects, handicaps, or genetic diseases? ❍ Yes ❍ No

___

Do you have aunts, uncles, cousins, nieces, nephews, grandparents or grandchildren with birth defects, handicaps, or genetic diseases? ❍ Yes ❍ No

___

Do you know of any family member with mental retardation (even mild) or learning disabilities? ❍ Yes ❍ No

___

Do you have children that have died other than in accidents? ❍ Yes ❍ No

___

Do you have any other medical conditions? ❍ Yes ❍ No

___

Birth Defect and Genetic Disease Examples

Anencephaly
Blindness or Eye Conditions
Bone Disorders
Cerebral Palsy
Chromosome Abnormality
Cleft Lip or Cleft Palate
Congenital Heart Defect
Cystic Fibrosis
Deafness
Down Syndrome (Mongolism)
Epilepsy
Genital Abnormalities
Hemophilia (Bleeding Tendency)
Hydrocephalus (Water on the Brain)
Infertility
Kidney Disease
Limb Defects
Malformations
Mental Illness
Mental Retardation
Muscular Dystrophy
Neurofibromatosis
Neurologic or Degenerative Disorder
Short Stature (Under 5 Feet Tall)
Skin Disease
Sickle Cell Anemia
Spina Bifida (Open Spine)
Urinary Tract Abnormality