



OBSTETRICS – GYNECOLOGY – INFERTILITY

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Congratulations on your pregnancy!

The Los Olivos physicians and staff look forward to working with you during your pregnancy. Please fill out the Genetics Questionnaire and the Prenatal Record prior to your first appointment and bring them to the appointment with you. We normally schedule the first OB appointment between 8 and 12 weeks of pregnancy. It is helpful if you know the first day of your last menstrual period (LMP) or when you ovulated. By tradition, the pregnancy starts with your LMP. If you experience any problems or have any bleeding prior to the first OB appointment, please call your doctor to discuss the need for an earlier appointment with a possible ultrasound.

We will give you a large amount of information about pregnancy at your first prenatal visit. You can access this information now at our website, www.lowmg.com. Please feel free to ask any questions during any of your visits. We recommend that you write them down so that you do not forget any of your concerns and all of your questions can be answered. Between appointments, you may call during office hours and leave non-urgent questions on the voice mail. Your calls will be returned within 24 hours.

During your first prenatal appointment, the paperwork you have completed will be reviewed. A complete history and physical exam will be performed including a pap smear if you have not had a recent examination.

Genetic testing will be discussed during your visit. Tests for cystic fibrosis, Tay-Sachs and sickle cell disease are available if desired. Nuchal screening, AFP testing, genetic amniocentesis and ultrasound testing will be reviewed.

Blood tests ordered at your first obstetric visit include testing for rubella, hepatitis, syphilis, anemia, low thyroid and blood type. We offer an HIV and cystic fibrosis testing to everyone. If you are unsure about whether you have had chicken pox (varicella), this may also be requested. A toxoplasmosis screen can be done if you have outdoor cats that use and indoor litter box. A urinalysis will also be performed.

We recommend that you take .4 to 1.0 mg of folic acid each day during the first trimester of your pregnancy. Folate is included in most non-prescription and prescription prenatal vitamins. If you would like a specific prenatal vitamin called in to your pharmacy, please have your pharmacy FAX us a request or leave a detailed voicemail with your physician.

We are pleased that you have chosen our office for your care. In establishing a successful patient-physician relationship, our philosophy is to treat our patients with courtesy you are due and to maintain excellent communications. We are partners in your care and we will work together with you to make your pregnancy a wonderful and memorable experience. We look forward to a safe and healthy pregnancy and delivery.

The Los Olivos staff

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Genetics Questionnaire

Patient name: _____ Physician: _____

Please answer the following questions carefully at your leisure and bring the answers along with you to your first obstetrical visit. Your answers may help identify problems with your pregnancy and/or indicate special tests necessary to evaluate your health or that of your unborn baby.

Family History and Genetic screening

1. Certain genetic diseases are more common in certain ethnic groups. Please check if you or the baby's father is one of these ethnic groups.

Yes No Eastern European Jewish ancestry
If yes, have you had Tay-Sachs screening tests? Yes No
If yes, have you had a Canavan screening test? Yes No

Yes No African American
If yes, have you had sickle cell screening? Yes No

Yes No European Ancestry
If yes, have you had cystic fibrosis screening? Yes No

Yes No Mediterranean Ancestry or Southeast Asian Ancestry
If yes, have you had screening for inherited forms of anemia such as thalassemia? Yes No

2. Have you or the baby's father had a child born with a birth defect? Yes No
If yes, please describe: _____

3. Did either you or the baby's father have a birth defect? Yes No
If yes, please describe: _____

4. Please describe any abnormalities that have occurred in children of your family or the baby's father's family (eg, mental retardation, birth defects, deformities or inherited diseases such as hemophilia, muscular dystrophy, cystic fibrosis or fragile X syndrome).

5. Do you have any other concerns about birth defects or inherited disorders?

6. Yes No Will you be 35 years or older at the time the baby is born?
 Yes No Will the father be 50 years or older at the time the baby is born?

Please list any surgical procedure that you have had:

1. Have you had a temperature of 103 or greater at any time during the first two months of your pregnancy? Yes No
2. Do you own a cat? Yes No
If yes, does your cat use a litter box? Yes No
Who changes the litter box _____
3. Have you used any hot tubs, saunas or steam baths during this pregnancy? Yes No
4. Do you have a history of a second trimester miscarriage or an incompetent cervix? Yes No
5. Have you had problems with preterm labor during a previous pregnancy? Yes No
6. Have you been treated for infertility? Yes No
List treatments: _____
7. Do you have any known abnormality or anomaly of your uterus? Yes No
8. Did your mother use DES when she was pregnant with you? Yes No
9. Do you and/or the baby's father have a history of herpes? Yes No
How often do you have outbreaks/year? _____
10. Do you have a history of venereal disease, such as gonorrhea, chlamydia or HIV? Yes No
11. Have you had any abnormal pap smears? Yes No
Dates: _____
12. Have you had a surgical procedure on your cervix such as a LOOP, LEETZ, or cone biopsy? Yes No
13. Do you have any close family members with tuberculosis? Yes No
14. Do you have a history of hepatitis, jaundice or liver disease? Yes No
15. Have you used cocaine, marijuana, or other drugs during this pregnancy? Yes No
16. Have you used alcohol during this pregnancy? Yes No
17. Do you smoke cigarettes? If yes, how many packs per day? _____ Yes No
18. Do you have any religious objections to any form of medical treatment (ie blood transfusions)? Yes No
19. Do you or any family member have a history of problems with anesthesia? Yes No
20. Do you have a latex allergy? Yes No
21. In the past year, have you been threatened, hit, slapped or kicked by anyone you know? Yes No
22. I have had chicken pox or have had a vaccination for it. Yes No
23. I am aware of the risks to myself and my baby of using alcohol, illicit or recreational drugs and smoking during pregnancy. Yes No

List all medications taken since your last menstrual period including prescription, over-the-counter and herbal medications:

Please list any concerns that you have:

Patient signature: _____ Date: _____

Due Date: _____

Patient name: _____ **Age:** _____
Home phone: _____ **Name of baby's father:** _____
Your work phone: _____ **Father's work phone:** _____
Your cell phone: _____ **Father's cell phone:** _____

If there is a family history of the following conditions please check next to that condition: NONE

- | | | | |
|---------------------------------------------|----------------------------------------------|---------------------------------------------|--------------------------------------|
| <input type="checkbox"/> Sickle cell anemia | <input type="checkbox"/> Tay Sachs | <input type="checkbox"/> Mental retardation | <input type="checkbox"/> Twins |
| <input type="checkbox"/> Bleeding problem | <input type="checkbox"/> Stillbirths | <input type="checkbox"/> Cystic fibrosis | <input type="checkbox"/> Thalassemia |
| <input type="checkbox"/> Heart defects | <input type="checkbox"/> Neural tube defects | <input type="checkbox"/> Musculodystrophy | |
- Any hereditary problems **Please explain:**

List any illnesses in your family:

Your partner: _____
 Your mother: _____
 Your father: _____
 Your brothers/sisters: _____

If you have a history of the following conditions please check next to that condition: NONE

- | | | | | |
|-------------------------------------------|------------------------------------------------------|------------------------------------------------|----------------------------------------------|---------------------------------------------|
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Colitis | <input type="checkbox"/> Infertility | <input type="checkbox"/> Alcohol use |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Herpes | <input type="checkbox"/> Heart disease | <input type="checkbox"/> Genital warts | <input type="checkbox"/> Seizure disorder |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Depression | <input type="checkbox"/> Fibroids | <input type="checkbox"/> Skin disorder | <input type="checkbox"/> Blood transfusion |
| <input type="checkbox"/> Drug use | <input type="checkbox"/> Smoking | <input type="checkbox"/> Group B streptococcus | <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Abnormal pap smear |
| <input type="checkbox"/> Thyroid disorder | <input type="checkbox"/> Frequent bladder infections | <input type="checkbox"/> Preterm labor | | |

Please explain any of the above check marks and list any other conditions:

List any surgeries: _____

Pregnancy history:

Last menstrual period: _____ Was this a planned pregnancy? yes no
 Last contraceptive used / date last used: _____ Last pap smear: _____
 Date of ovulation (if known): _____ Date of positive pregnancy test: _____
 Any illness, x-rays or injuries during pregnancy? yes no
 Have you had chicken pox? yes no unsure
 How tall are you? _____ What is your current weight? _____ What is your pre-pregnancy weight? _____
 Please list any medications used during the pregnancy. Are you taking prenatal vitamins? yes no

Do you have allergies to any medications? Please list _____

Previous pregnancies: Number of children now living _____ Number of live births _____

Number of miscarriages _____ Number of pregnancy terminations _____

Number of ectopic pregnancies _____

Were there any complications to you or the baby during any of the pregnancies or deliveries? NO

Date of delivery	Hospital	Vaginal or cesarean	Natural or epidural	Weight of baby	Gestational age at del.	Length of labor

Patient signature: _____ Date: _____