Stephanie Mandelman M.D.
Ob/Gyn

New OB Patient Info

Please fill out to the best of your ability.

1. Do you have any drug allergies?(if so please list)_____
2. Latex allergies? [ ]Yes [ ]No
3. Is a blood transfusion acceptable? [ ]Yes [ ]No
4. Antepartum Anesthesia consult planned? [ ]Yes [ ]No
5. Please list all medications you are currently on, please include dosage:_____

_____

Delivery Confirmation:

1. What was the FIRST day of your last period?_____
2. Have you had any OB care before today?_____
   If so what physician?_____

Medical History: Please answer positive or negative, detail any positive answers.

1. Diabetes:_____
2. Hypertension:_____
3. Heart Disease:_____
4. Autoimmune Disorder:_____
5. Kidney Disease/UTI:_____
6. Neurologic/Epilepsy:_____
7. Psychiatric:_____
8. Depression/Postpartum Depression:_____
9. Hepatitis/Liver Disease:_____
10. Varicosities/Phlebitis:_____
11. Thyroid Dysfunction:_____
12. Trauma/Violence:_____
13. History of Blood Transfusion:_____
14. D (Rh) Sensitized:_____
15. Pulmonary (TB, Asthma):_____
16. Seasonal Allergies:_____
17. Breast:_____
18. Gyn Surgery:_____

____

19. Operations/Hospitalizations (year & reason):_____
20. Anesthetic Complications:_____
21. History of Abnormal Paps:_____
22. Uterine Anomaly/DES:_____
23. Infertility:_____
24. Any Relevant Family History:_____
25. Tobacco Use: Pre-Pregnancy Use:[ ]Yes [ ] No__Date You Quit:_____Years of Use:_____

Genetic History & Screening:

Includes Patient, Baby's Father, or anyone in either family with:

1. Patient's age 35 years or older as of estimated time of delivery: [ ]Yes [ ] No
2. Thalassemia (Italian, Greek, Mediterranean, or Asian background) MCV less than 80: [ ]Yes [ ] No
3. Neural Tube Defect (Meningomyelocele, Spina Bifida, or Anencephaly):[ ]Yes [ ] No
4. Congenital Heart Defect: [ ]Yes [ ] No
5. Down Syndrome: [ ]Yes [ ] No
6. Tay-Sachs (Ashkenazi Jewish, Cajun, French Canadian): [ ]Yes [ ] No
7. Canavan Disease (Ashkenazi Jewish): [ ]Yes [ ] No
8. Familial Dysautonomia (Ashkenazi Jewish): [ ]Yes [ ] No

9. Sickle Cell Disease or Trait (African): [ ]Yes [ ] No
10. Hemophililia or other Blood Disorders: [ ]Yes [ ] No
11. Muscular Dystrophy: [ ]Yes [ ] No
12. Cystic Fibrosis: [ ]Yes [ ] No
13. Huntington's Chorea: [ ]Yes [ ] No
14. Mental Retardation/Autism: [ ]Yes [ ] No
    If yes, was person tested for the Fragile X mutation: [ ]Yes [ ] No
15. Other inherited genetic or chromosomal disorder: [ ]Yes [ ] No
16. Maternal Metabolic Disorder (EG, Type 1 Diabetes, PKU): [ ]Yes [ ] No
17. Patient Or Baby's Father had a child with Birth Defects not listed above: [ ]Yes [ ] No
18. Recurrent Pregnancy Loss, or a Stillbirth: [ ]Yes [ ] No
19. Medications (including supplements, vitamins, herbs or other over the counter drugs)/ Illicit/ Recreational Drugs/ Alcohol since last menstrual period: [ ]Yes [ ] No If yes please list:_____

Infection History:

1. Live with someone with TB or Exposed to TB: [ ]Yes [ ] No
2. Patient or Partner has history of Genital Herpes: [ ]Yes [ ] No
3. Rash or Viral Illness since last menstrual period: [ ]Yes [ ] No
4. Hepatitis B, C: [ ]Yes [ ] No
5. History of STD, Gonorrhea, Chlamydia, HPV, HIV, Syphilis: [Circle all that apply]