

New Patient Pregnancy Confirmation Form

Patient Name: _____

Date of Birth: _____

Date: _____

1. Have you ever had issues with depression, including post-partum depression? Yes / No
2. Are there cats in your home? Yes / No
3. Have you had chicken pox in the past? Yes / No
4. Do you live with someone with tuberculosis or who has been exposed to tuberculosis? Yes / No
5. Have you had a rash or viral illness since your LMP? Yes / No
6. Do you have any history of sexually transmitted infections not including HPV? (gonorrhea, chlamydia, syphilis, genital herpes, trichomoniasis, hepatitis) Yes / No
7. Does your partner have a history of genital herpes? Yes / No
8. Have you ever had MRSA? Yes / No
9. Have you or your partner traveled to any areas with the Zika Virus? Yes/ No
10. Do you have any current or past use of non-prescription drug use including marijuana? Yes/No If yes which drugs? _____
11. When was your last flu shot? _____
12. Are you or the baby's father of Jewish, French Canadian or Cajun Ancestry? Yes / No
13. Do you have any potential environmental exposures you would like to discuss? Yes / No
If yes, what was the exposure _____
14. Have you ever had trouble with anesthesia? Yes / No
If so, please explain _____
15. Do you or the baby's father have a personal or family history of any of the following?

		If yes, which family member (s) is/are affected?
Thalassemia	Yes / No	
Neural tube defect (e.g. Spina bifida)	Yes / No	
Congenital heart defect	Yes / No	
Down Syndrome	Yes / No	
Tay-Sachs	Yes / No	
Canavan's Disease	Yes / No	
Sickle cell disease or trait	Yes / No	
Hemophilia or other blood disorders	Yes / No	
Muscular Dystrophy	Yes / No	
Cystic Fibrosis	Yes / No	
Huntington's Chorea	Yes / No	
Mental Retardation or Autism	Yes / No	
Fragile X	Yes / No	
Maternal metabolic disorder	Yes / No	
Recurrent pregnancy loss or stillbirth	Yes / No	

HARBOUR WOMEN'S HEALTH



OBSTETRICS ● GYNECOLOGY ● UROGYNECOLOGY

Autoimmune Disorder	Yes / No	
Hepatis / Liver Disease	Yes / No	
Other genetic or chromosomal disorder	Yes / No	
Other birth defect	Yes / No	