MONTEFIORE MEDICAL CENTER
The University Hospital for the ALBERT EINSTEIN COLLEGE OF MEDICINE

Department of Obstetrics & Gynecology and Women's Health
Division of Reproductive Genetics

Patient History (Social, Family and Medical)

Patient Name _____ Social Security # _____

Address _____

City _____ State _____ Zip Code _____

Phone Number (Home) _____ (Work) _____

Date of Birth ____ / ____ / _____ Age _____ Occupation _____

Race/Ethnicity ☐ Caucasian ☐ African American ☐ Hispanic ☐ Asian ☐ Other _____

Religious Affiliation _____ Blood Type _____

Last Menstrual Period ____ /____ /____ Date of Sonogram _____ /_____/_____ Weeks _____

Name of Baby's Father _____

Date of Birth ____ / ____ / _____ Age _____ Occupation _____

Race/Ethnicity ☐Caucasian ☐ African American ☐ Hispanic ☐ Asian ☐ Other _____

Review of Systems

*Please answer **YES** ior **NO** if you have any of the following medical problems*

YES	NO	ILLNESS
☐	☐	Diabetes
☐	☐	High Blood Pressure
☐	☐	Heart Disease
☐	☐	Autoimmune Diseases such as Arthritis or Lupus
☐	☐	Kidney Diseases
☐	☐	Urinary Tract Infection
☐	☐	Neurologic Disease such as Seizures or Epilepsy
☐	☐	Hepatitis, Yellow Jaundice, or other Liver Diseases
☐	☐	Bowel Problems
☐	☐	Phelbitis or other varicosities (swelling of blood vessels)
☐	☐	Recurrent Pregnancy Loss
☐	☐	Infertility (difficulty in getting pregnant)
☐	☐	Thyroid Problems
☐	☐	Muscle Weakness
☐	☐	Skin Problems
☐	☐	Hearing or Vision Problems
☐	☐	Allergies
☐	☐	Anemia, History of Blood Transfusion
☐	☐	Rh Incompatibility (Rh negative)
☐	☐	Lung disease such as Asthma
☐	☐	Operations and Hospitalizations
☐	☐	Trauma or Domestic Violence
☐	☐	Cancer
		If yes, where? _____

Past Pregnancies

Please list in chronological order, including living children (names, sex, dates of birth, birth weight, and present health status) and miscarriages, abortions, stillbirths, premature births and early infant deaths.

_____
_____
_____
_____
_____

Medications

Please list all medications, prescriptions and over-the-counter drugs taken during this pregnancy

MEDICATIONS **DOSAGE** **REASON FOR MEDICATION**

_____
_____
_____

Current Pregnancy

Please answer YES or NO to the following questions regarding this pregnancy

Smoking ☐ Yes ☐ No # of Cigarettes per day _____ Years _____

Alcohol ☐ Yes ☐ No # of Drinks per day _____ Drinks per week _____

Drug Use ☐ Yes ☐ No *If Yes, name of drug(s)* _____

_____

Have you or the baby's father had X-rays in the past six months?

If Yes, please explain _____

Does the baby's father have any medical problems?

If Yes, please explain _____

If the results indicate a fetal abnormality, would you consider an abortion? ☐ Yes ☐ No

Completed By: ☐ **Patient** ☐ **Office Staff** ☐ **Physician/Medical Provider**

Signature of Patient _____

Date Reviewed by Physician with Patient _____

Physician Signature _____

Comments _____

_____

_____

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Cystic Fibrosis Carrier Screening

Cystic Fibrosis (CF) is the most common severe and usually fatal inherited disease in Caucasian families. CF clogs the lungs and pancreas with thick mucus and causes severe breathing and digestive problems. CF occurs in about 1 in 3,300 births in the United States.

To have a child with CF, both parents must be carriers of a change in the CF gene. The carrier rate and the ability to detect a carrier are different in various ethnic groups, as shown below:

Race or Ethnicity	# of Babies Born	Chance of Being a Carrier	Carrier Detection Rate
Northern European	1/2,500	1/25 - 1/29	85 - 90%
Southern European	1/2,500	1/25 - 1/29	70%
Ashkenazi Jewish	1/2,800	1/26 - 1/29	97%
Hispanic	1/8,100	1/46	57%
African American	1/14,500	1/60 - 1/65	72%
Asian	1/32,000	1/90	30%

Because we cannot detect all carriers, a negative screen does not guarantee an unaffected pregnancy. It is your decision to have or not to have this blood test.

Please check below:

☐ **Yes,** I would like to have CF screening

☐ **No,** I am not interested in CF screening

Print Name: _____

Signature: _____ Date _____ / _____ / _____

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ALBERT EINSTEIN
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OF YESHIVA UNIVERSITY

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(718) 405-8150 Office
(718) 405-8151 Fax

TO ALL PATIENTS:

The Department of Obsterics & Gynecology and Women's Health, Division of Reproductive Genetics is committed to protecting your health information. This makes it very difficult to communicate with a family member or to leave a message on your answering machine. Please indicate below your permission to speak to a family member (specify name), or to leave a message on your answering machine. Please be advised this authorization will **expire one year** from date signed.

I hereby give permission to the Division of Reproductive Genetics to:

A) Leave a message on my answering machine at (Phone #) _____

B) Leave test results on my answering machine ☐ Yes ☐ No

Phone # _____

C) Give information regarding test results to me and _____
Name of other person

_____ _____

Signature of Patient *Date Signed*