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OB RISK ASSESSMENT

Patient Name **Today's Date (MM/DD/YYYY)**

Will you be 35 or older, or will your partner be 55 or older when the baby is due? ___ yes ___ no

Have you had any medications, X-rays, viral illnesses, or unexplained rashes since you think you got pregnant? List when and what. ___ yes ___ no

Have you used tobacco, alcohol, or illegal drugs since becoming pregnant? ___ yes ___ no

Have you or your partner had herpes—genital, oral or cold sores? ___ yes ___ no

Did you have PKU (phenylketonuria) as a child? ___ yes ___ no

Have you had chicken pox (Varicella) or the vaccine? (Circle which applies) ___ yes ___ no

Have you ever had parvovirus (5th Disease) or been tested for it? ___ yes ___ no

Does/did anyone in the baby's father or your family or your family have a baby with: ___ yes ___ no

a.) Down syndrome or other intellectual disability? ___ yes ___ no
b.) Spina Bifida, meningomyelocele (open spine)? ___ yes ___ no
c.) Hemophilia, muscular dystrophy? ___ yes ___ no
d.) Hydrocephalus (water on the brain)? ___ yes ___ no
e.) Congenital heart defect? ___ yes ___ no
f.) Huntington's chorea? ___ yes ___ no
g.) Cystic fibrosis? ___ yes ___ no
h.) Developmental delay, autism, menopause before age 40, family history of Fragile X? ___ yes ___ no
i.) Other known or suspected inherited or genetic conditions or birth defects? List. ___ yes ___ no

Have you or the baby's father conceived pregnancies that resulted in three or more spontaneous miscarriages in the past? ___ yes ___ no

Are you or the baby's father Black or East Indian? ___ yes ___ no
If yes, have you or the father of the baby had sickle cell carrier testing? ___ yes ___ no

Are you or the baby's father ASHKENAZI JEWISH, PENNSYLVANIA DUTCH, LOUISIANA CAJUN, OR QUEBEC FRENCH CANADIAN? ___ yes ___ no
If yes, have you or the father of the baby had Tay-Sachs carrier testing? ___ yes ___ no

Are you or the baby's father ITALIAN or GREEK? ___ yes ___ no
If yes, have you or the father of the baby had thalassemia carrier testing? ___ yes ___ no

Are you the victim of emotional or physical abuse? ___ yes ___ no

Do you have any concerns not covered by the above? ___ yes ___ no

Patient Signature **Today's Date (MM/DD/YYYY)**

Physician Authorization **Today's Date (MM/DD/YYYY)**