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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)**