Mariposa Perinatal Services

Mladen Predanic, MD, MSc, FACOG
Maternal Fetal Medicine

Date: __________

Name: ____ Date of Birth: _____/_____/_________

Height: ________ Weight: ________ Pre-pregnancy weight: ___________

First day of your last menstrual period: _____/_____/______ DUE DATE (if known): _____/_____/_________

Have you had a sonogram (ultrasound) during the current pregnancy? ☐ Yes ☐ No

Do you wish to know the sex (gender) of the baby? ☐ Yes ☐ No

Is this an IVF or IUI (fertility treated) or similar pregnancy? ☐ Yes ☐ No

ANY PROBLEMS with your current pregnancy? ____

OBSTETRICAL HISTORY (number of prior pregnancies, if any):

☐ Number of TOTAL pregnancies
☐ Number of pregnancies carried to FULL TERM (>37w0d gestation)
☐ Number of pregnancies delivered PREMATURELY (<37w0d gestation)
☐ Number of tubal/ectopic [ ] and/or miscarriages [ ] and/or induced abortion [ ] pregnancies
☐ Number of MULTIPLE births
☐ Number of LIVING children

Complete the table below for each pregnancy (living or deceased) start with your first pregnancy

Year	At gestational week (full term = 40w)	Labor Length (hr.)	Birth Weight	Sex (M or F)	Type of Delivery (Vaginal vs. CESAREAN*)*	Place of Birth

How would you describe YOUR ancestry (check all that applies):

☐ White ☐ African ☐ Hispanic ☐ Asian _____________ ☐ Middle Eastern
☐ Native American ☐ Jewish ☐ French Canadian ☐ Indian ☐ Unknown Race
☐ Other ____

How would you describe the ancestry of the FATHER of THIS BABY (check all that applies):

☐ White ☐ African ☐ Hispanic ☐ Asian _____________ ☐ Middle Eastern
☐ Native American ☐ Jewish ☐ French Canadian ☐ Indian ☐ Unknown Race
☐ Other ____

Are you and the father of this baby blood relatives (e.g. cousins)? ☐ Yes ☐ No

Is the father of this baby your partner? ☐ Yes ☐ No

What is the AGE of the father of this baby? ________ years old

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What is your occupation? ____

Have you had exposure to?

Cat litter	☐ Yes ☐ No	X-Rays	☐ Yes ☐ No	Chemicals	☐ Yes ☐ No
Fever	☐ Yes ☐ No	Infections	☐ Yes ☐ No	Rashes	☐ Yes ☐ No

Do you smoke? ☐ Yes ☐ No If yes, how much? _______________

Have you consumed any drugs (including cannabis or alcohol) ☐ Yes ☐ No If yes, which one? ______________

Have you taken any **MEDICATIONS** during last 12 months? ☐ Yes ☐ No

If yes - Medication name	
	Are you still on this medication ☐ Yes ☐ No
	Are you still on this medication ☐ Yes ☐ No
	Are you still on this medication ☐ Yes ☐ No
	Are you still on this medication ☐ Yes ☐ No
	Are you still on this medication ☐ Yes ☐ No
	Are you still on this medication ☐ Yes ☐ No
	Are you still on this medication ☐ Yes ☐ No

Past Surgeries (if any):

Year	Type of Surgery	Complications	Where?

Your **blood type** if known (circle): O A B AB Rh factor: negative positive

ALLERGIES

		If yes, which one (to what)?
Allergic to any MEDICATION?	☐ Yes ☐ No	______________________
Any other known allergies?	☐ Yes ☐ No	______________________
OTHER:		______________________

History of the following CONDITIONS/DISORDERS:	PERSONAL	Family member	(Who?)
Unexplained fever	☐ Yes ☐ No	☐ Yes ☐ No	
Asthma or other lung problems (including Cystic Fibrosis)	☐ Yes ☐ No	☐ Yes ☐ No	
Heart murmur or other heart disease	☐ Yes ☐ No	☐ Yes ☐ No	
High blood pressure	☐ Yes ☐ No	☐ Yes ☐ No	
Liver problems	☐ Yes ☐ No	☐ Yes ☐ No	
Bladder or Kidney infections or kidney stones	☐ Yes ☐ No	☐ Yes ☐ No	
Diabetes (high blood sugar)	☐ Yes ☐ No	☐ Yes ☐ No	
Thyroid problems	☐ Yes ☐ No	☐ Yes ☐ No	
Other hormone (endocrine) problems	☐ Yes ☐ No	☐ Yes ☐ No	
Epilepsy or seizure disorder	☐ Yes ☐ No	☐ Yes ☐ No	
Migraine or cluster headaches	☐ Yes ☐ No	☐ Yes ☐ No	
Depression or other psychiatric disorder	☐ Yes ☐ No	☐ Yes ☐ No	
Skin problems	☐ Yes ☐ No	☐ Yes ☐ No	
Arthritis, joint pains or rheumatoid disease	☐ Yes ☐ No	☐ Yes ☐ No	
Lupus (systemic) or other connective tissue disorder	☐ Yes ☐ No	☐ Yes ☐ No	
History of rheumatic fever	☐ Yes ☐ No	☐ Yes ☐ No	
History of blood transfusion	☐ Yes ☐ No	☐ Yes ☐ No	
History of blood clots (DVT or pulmonary embolism)	☐ Yes ☐ No	☐ Yes ☐ No	
Congenital Heart Defect	☐ Yes ☐ No	☐ Yes ☐ No	
Thalassemia or Sickle cell trait/disease	☐ Yes ☐ No	☐ Yes ☐ No	
Neural Tube Defect (e.g. Spina Bifida and similar)	☐ Yes ☐ No	☐ Yes ☐ No	
Inherited Genetic or Chromosomal disorder	☐ Yes ☐ No	☐ Yes ☐ No	
Muscular Dystrophy	☐ Yes ☐ No	☐ Yes ☐ No	
Cognitive delays or Autism or Learning Disorder	☐ Yes ☐ No	☐ Yes ☐ No	
Breast, ovarian or colon cancer	☐ Yes ☐ No	☐ Yes ☐ No	
OTHER:	☐ Yes ☐ No	☐ Yes ☐ No	

OFFICE USE ONLY

years old, G P at weeks gestation by 1st trimester ultrasound (not) confirmed EDD.

Significant LABs:

PROBLEM LIST:

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