1. Last Name	First Name	MI
2. Patient Number		
3. Date of Birth (MM/DD/YYYY)	Month / Day / Year	
4. Race ☐ American Indian or Alaska Native ☐ Asian ☐ Black/African American ☐ Native Hawaiian/Other Pacific Islander ☐ Unknown ☐ White		
5. Ethnic Origin ☐ Hispanic Cuban ☐ Hispanic Mexican American ☐ Hispanic Other ☐ Hispanic Puerto Rican ☐ Not Hispanic/Latino ☐ Unreported		
6. Gender ☐ Female ☐ Male		
7. County of Residence		

N.C. Department of Health and Human Services
Division of Public Health
Women's and Children's Health Section

MATERNAL HEALTH HISTORY — Part B

(See Instructions)

GENETIC / TERATOLOGY HISTORY — Circle If More Then One Response In Item Number Applies
Includes Patient, Baby's Father, or Anyone in Either Family with:
(Detail positive findings below in comments / counseling section)

	Patient	Family	Father of Baby		Patient	Family	Father of Baby
1. Patient's Age ≥ 35 Years				12. Tay-Sachs			
2. Down Syndrome				13. Huntington Chorea			
3. Cystic Fibrosis				14. Canavan, Dysautonomia			
4. Sickle Cell Disease				15. Maternal Metabolic Disorder (ex: Type I Diabetes, PKU)			
5. Sickle Cell Trait				16. Muscular Dystrophy			
6. Congenital Heart Defect				17. Patient or FOB had a Child with Birth Defects not Listed Above			
7. Neural Tube Defect (spina bifida, meningomyelocele or anencephaly)				18. Recurrent Pregnancy Loss, or a Stillbirth			
8. Thalassemia				19. Other Inherited Genetic or Chromosomal Disorder			
9. Mental Impairment or Retardation/Autism If yes, was person tested for Fragile X?				20. Any medications either prescribed or non-prescribed since your last Menstrual Period? Name/ Type_____			
10. Hemophilia or other blood disorders				21. Occupational / Environmental Hazards (i.e., second hand smoking/lead exposure)			
11. RH sensitized				22. Other i.e. Alcohol, street drugs			

COMMENTS / COUNSELING: _____

INFECTION/IMMUNIZATION HISTORY — Circle All That Apply In Each Item Number
(Detail positive findings below in comments / counseling section)

	YES	NO		YES	NO
1. High Risk for Hepatitis A/ B/C? Immunized ☐ Yes ☐ No **Date**_____			7. Exposure to or History of Mumps? Immunized ☐ Yes ☐ No **Date**_____		
2. Lives with Someone with TB or Exposed to TB			8. Rash or Viral Illness since Last Menstrual Period		
3. Patient or Partner has History of Genital Herpes			9. History of HIV and/or GC, Chlamydia, HPV, Syphilis, and/ or other Sexually Transmitted Infections		
4. Exposure to or History of Rubeola? Immunized ☐ Yes ☐ No **Date**_____			10. History of Toxoplasmosis and/or Cytomegalovirus		
5. Exposure to or History of Rubella? Immunized ☐ Yes ☐ No **Date**_____			11. History of a Newborn with Group B Streptococcus (GBS) (not the mother, but the newborn diagnosed with GBS)		
6. Exposure to or History of Varicella Zoster (Chicken Pox)? Immunized ☐ Yes ☐ No **Date**_____			12. Other (specify)		

COMMENTS / COUNSELING: _____

Signature: _____ Date: _____

Interpreter Used ☐ N/A ☐ No ☐ Yes Interpreter Name _____

MATERNAL HEALTH HISTORY — PART B
(Genetics and Teratology History)
Instructions

Purpose: To obtain a genetic history and teratology history in order to assist in identifying the patient whose baby may be at risk for birth defects or inherited disorders. Screening for genetic disorders should be provided based on the patient's racial, ethnic, and family background.

Instructions: Refer to link http://whb.ncpublichealth.com/provPart/forms.htm for a list of definitions pertaining to this form, print and use as needed.

This form is to be completed by the appropriate staff and reviewed by the clinical provider. Use agency policy approved codes. This form is not a mandatory form and may be used at the discretion of the health department.

Disposition: This form is to be retained in accordance with the records disposition schedule of medical records as issued by the Division of Archives and History.

Location: Go to the following link to access this form and print as needed:
http://whb.ncpublichealth.com/provPart/forms.htm