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, Infant's Father, or Anyone in Either Family with:
(Detail positive findings below in comments / counseling section)

	Patient	Family	Father of Infant		Patient	Family	Father of Infant
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. Intellectual Disability/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/electronic nicotine devices/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 patient, 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)
Definitions

GENETIC/TERATOLOGY HISTORY

Obtaining a genetic history (genetic defects or chromosomal abnormalities that can cause birth defects or disorders) and teratology history (factors or substances that can cause birth defects or disorders) will assist in identifying the patient whose infant 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.

For items 1–22. Place your agency's appropriate code in the corresponding space to indicate responses for history of patient, father of infant, and family.

Note instruction details in order to clarify the following items:

2. **Down Syndrome:** a congenital disorder caused by having an extra 21st chromosome; results in a flat face and short stature and intellectual disability.
3. **Cystic Fibrosis:** includes meningomyelocele, spina bifida, or anencephaly.
4. **Sickle Cell Diseases:** a genetic blood **disease** due to the presence of an abnormal form of hemoglobin (red blood cell); affects predominately African American decents, but could affect Hispanics and others.
5. **Sickle Cell Trait:** the condition in which a person carries the gene for sickle cell disease, but does not have the disease.
6. **Congenital Heart Defect:** being born with a birth defect involving the heart.
7. **Neural Tube Defect (spina bifida, meningogyelocele or anencephaly):** Born with a defect involving the spinal column.
8. **Thalassemia:** primarily affects persons of Italian, Greek, Mediterranean, and/or Asian ancestry; Mean Corpuscular Volume (MCV) less than 80.
9. **Intellectual Disability/Autism:** If yes, was person tested for Fragile X?
10. **Hemophilia/other blood disorders:** a genetic disorder that often results in excessive bleeding.
11. **RH Sensitized:** when a patient has RH — negative blood and it mixes in utero with a RH — positive blood type infant, the patient's immune system response to the mixing of both blood types. This immune response is called RH Sensitized or RH Sensitization.
12. **Tay-Sachs:** primarily affects persons of Jewish, Cajun, and/or French Canadian ancestry.
13. **Huntington Chorea:** is a disorder passed down through families in which nerve cells in the brain waste away, or degenerate.
14. **Canavan:** an inherited condition that affects the breakdown and use of amino acids; primary affects Ashkenazi Jews.
15. **Maternal Metabolic Disorder:** includes, for example, all types of diabetes and phenylketonuria (PKU) or other disorders with metabolite accumulation.
16. **Muscular dystrophy:** a genetic disorder that affects the muscular system causing weakness and wasting of skeletal muscles.
17. **Patient or FOB had a child with birth defects not listed above**
18. **Recurrent Pregnancy Loss, or a Stillbirth:** any pregnancies resulting in miscarriages, ectopics, fetal death, etc
19. **Other inherited Genetic or Chromosomal Disorder**
20. **Any medications either prescribed or non-prescribed since your last Menstrual Period?**
21. **Occupational/Environmental Hazards:** includes exposures to second hand smoke/electronic nicotine devices/lead exposure, potential hazards, for examples, pollutants, chemicals, x-rays, working with raw meat/poultry, exposure to cat feces (toxoplasmosis risk), and working in day care centers and nurseries (cytomegalovirus risk).

22. **Other:**

INFECTION HISTORY

Taking an infection history refers to the patient's personal history of having or being at risk for infections that may adversely affect the pregnancy or birth outcome. An adequate history will assist in assuring that appropriate screening, monitoring, treatment, and follow-up are completed.

For items 1–12. Place the appropriate code in the corresponding space, using the legend of codes at the bottom of the form to indicate responses for each item of the infection history. Place an N for No or a Y for Yes.

Note instruction details for the following items:

1. **High risk Hepatitis B (HBV):** risks for HBV infection include sexual exposure to persons known or suspected to be infected with HBV; household or institutional contacts with chronic HBV carriers; intravenous drug use; occupational exposure via contaminated blood and body fluids; and/or recipient of blood transfusions or hemodialysis. Indicate if immunized and date received.
2. **Tuberculosis (TB):** indicate if patient lives with someone who has been diagnosed and/or is being treated for TB or if the patient has been exposed to TB.
3. **Genital Herpes:** indicate if the patient or her sexual partner has a history of genital herpes.
4. **Rubeola (Red Measles):** indicate past exposure to and/or history of rubeola infection. Indicate if immunized and date received.
5. **Rubella (German Measles):** indicate past exposure to and/or history of rubella infection. Indicate if immunized and date received.
6. **Varicella Zoster (Chicken Pox):** indicate past exposure to and/or history of chicken pox infection. Indicate if immunized and date received.
7. **Mumps:** indicate past exposure to and/or history of having had mumps. Indicate if immunized and date received.
8. **Rash or Viral Illness:** indicate if patient has had a rash or symptoms of a viral illness since the last menstrual period.
9. **HIV/Sexually Transmitted Infections:** indicate if patient has a history of HIV and/or any sexually transmitted infection including gonorrhea (GC), chlamydia, human papillomavirus (HPV), and syphilis.
10. **Toxoplasmosis or Cytomegalovirus:** indicate if patient has a history of having either infection.
11. **Group B Streptococcus (GBS):** indicate if patient has a history of having a GBS infection. Refer to your agency's protocols and established strategies for screening for GBS in collaboration with local obstetricians and pediatricians, local hospital staff and staff from tertiary centers.
12. **Other:** Specify any other infection history not included in items 1–11.

Comments/Counseling

Below the Genetic/Teratology History and the Infection History, detail positive findings in the comments/counseling section. Also document any counseling provided as a result of any positive findings and any other pertinent comments. Explain pertinent information that may impact patient care, whether or not a significant problem. If more space is needed, refer to the "Notes" section of the chart and record additional information.

Signature/Date

Below each history section the interviewer should provide signature and date where indicated.

Instructions

Purpose: To obtain a genetic history and teratology history in order to assist in identifying the patient whose infant 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: 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.