

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

## MATERNAL HEALTH HISTORY — Part B

(See Instructions)

**GENETIC / TERATOLOGY HISTORY — Circle If More Than 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			
7. Neural Tube Defect (spina bifida, meningocele or anencephaly)				18. Recurrent Pregnancy Loss, or a Stillbirth			
8. Thalassemia				19. Other Inherited Genetic or Chromosomal Disorder			
9. Intellectual Disability 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							

**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 <input type="checkbox"/> Yes <input type="checkbox"/> No Date _____			7. Exposure to or History of Mumps? Immunized <input type="checkbox"/> Yes <input type="checkbox"/> 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 <input type="checkbox"/> Yes <input type="checkbox"/> No Date _____			10. History of Toxoplasmosis and/or Cytomegalovirus		
5. Exposure to or History of Rubella? Immunized <input type="checkbox"/> Yes <input type="checkbox"/> 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 <input type="checkbox"/> Yes <input type="checkbox"/> No Date _____					

**COMMENTS / COUNSELING:** \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_  
 Interpreter Used  N/A  No  Yes Interpreter Name \_\_\_\_\_