Tepeyac OB/GYN
Something More Than Medicine™

4001 Fair Ridge Drive, Suite 304
Fairfax, VA 22033
(703) 273-9440
www.tepeyacobgyn.com

Name: _____ Date of Birth:_____ Today's Date: _____

Obstetric Medical & Genetic Survey

Thank you for choosing Tepeyac Family Center for your pregnancy. We look forward to walking with you through this exciting time and aim to provide you and your pre-born baby with comprehensive and excellent medical care. To do so, we must assess your risk for various medical conditions, genetic disorders, and infectious diseases. Your answers, like your entire medical record, are kept strictly confidential. Please provide as accurate and complete information as possible so we may best serve you.

OB/GYN History

Please list all previous pregnancies including term, preterm, miscarriage & abortion.

First day of last period: ___ / ___ / _____ ❒ Regular ❒ Irregular	Name	DOB	Weeks pregnant	Vaginal or C-section	Anesthesia	Hours of labor	Place of birth	Weight	Complications & Health
Date of ovulation (if known): ___ / ___ / _____									
Weight prior to pregnancy: _____									

Personal & Family Medical History

Please check if any of the following medical conditions apply to **you** or to a member of **your family**.

Condition	√	Comments	Condition	√	Comments
Allergies (seasonal)			Liver disease		
Anemia/blood disorder			Neurologic disorder		
Asthma/pulmonary disorder			Kidney/renal disease		
Autoimmune disorders			Rh-negative		
Abnormal Pap Smear			Thyroid disorder		
Previous Blood Transfusion			Previous trauma/accident		
Breast disorder			Reproductive abnormality		
Depression			Varicosities or blood clot		
Other psychiatric disorder			Anesthesia complications		
Diabetes (gestational, other)			Other medical condition		
Heart Disease					
High blood pressure			Tobacco use & packs/day		
Infertility			Alcohol use & drinks/day		
			Recreational or IV drug use		

Turn over →

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Genetic Screening

Please check if any of the following genetic conditions apply to **you**, the **father of the baby**, or **either of your families**. Provide further details in the comments section.

Condition	√	Comments	Condition	√	Comments
Your age >35 at due date			Autism		
Neural tube defect (ie. spinal bifida)			-- If Yes, were they tested for Fragile X?		
Down Syndrome			Mental Retardation		
Congenital Heart Defect			-- If Yes, were they tested for Fragile X?		
Cystic Fibrosis			Muscular Dystrophy		
Tay-Sachs			Sickle cell disease or trait		
Thalassemia			Other genetic disorder		
Canavan Syndrome			Maternal metabolic disorder (ie. PKU)		
Hemophilia or hematologic disease			3+ miscarriages, or previous stillborn		
Huntington's Chorea			Other birth defects		

Exposure to Infectious Diseases

	Yes/No	Comments
Are you or your partner HIV-positive? - Have either of you ever used IV drugs? - Have either of you had other partners in the past 5 years? - Have either of you had sexual contact with men who have sex with men?	Y / N Y / N Y / N Y / N	
Have you or your partner had genital herpes?	Y / N	
Have you ever been exposed to active tuberculosis? - Have you lived with someone with TB? - Have you lived in a country with high rates of TB? - Have you lived in a communal home, shelter or prison?	Y / N Y / N Y / N Y / N	
Since your last period, have you had a rash or viral illness?	Y / N	
Have you ever been diagnosed or treated for a sexually transmitted infection? (ie. chlamydia, gonorrhea, syphilis)	Y / N	
Have you had the chicken-pox in the past? - If not, have you received the vaccine?	Y / N Y / N	
Have you been previously diagnosed with any other infectious disease?	Y / N	
Do you own or regularly come in contact with a cat?	Y / N	