



OB RISK ASSESSMENT

Patient Name

Today's Date (MM/DD/YYYY)

Will you be 35 or older, or will your partner be 55 or older when the baby is due? ___ yes ___ no

Have you had any medications, X-rays, viral illnesses, or unexplained rashes since you think you got pregnant?
 List when and what. ___ yes ___ no

Have you used tobacco, alcohol, or illegal drugs since becoming pregnant? ___ yes ___ no

Have you or your partner had herpes—genital, oral or cold sores? ___ yes ___ no

Did you have PKU (phenylketonuria) as a child? ___ yes ___ no

Have you had chicken pox (Varicella) or the vaccine? (Circle which applies) ___ yes ___ no

Have you ever had parvo virus (5th Disease) or been tested for it? ___ yes ___ no

Does/did anyone in the baby's father or your family or your family have a baby with: ___ yes ___ no

- a.) Down syndrome or other mental retardation? ___ yes ___ no
- b.) Spina Bifida, meningomyelocele (open spine)? ___ yes ___ no
- c.) Hemophilia, muscular dystrophy, cystic fibrosis? ___ yes ___ no
- d.) Hydrocephalus (water on the brain)? ___ yes ___ no
- e.) Congenital heart disease? ___ yes ___ no
- f.) Huntington's Chorea? ___ yes ___ no
- g.) Cystic fibrosis? ___ yes ___ no
- h.) Developmental delay, autism, menopause before age 40, family history of Fragile X? ___ yes ___ no
- i.) Other known or suspected inherited or genetic conditions or birth defects? ___ yes ___ no

List: ___ yes ___ no

Have you or the baby's father conceived pregnancies that resulted in three or more spontaneous miscarriages in the past? ___ yes ___ no

Are you or the baby's father Black or East Indian? ___ yes ___ no

If yes, have you or the father of the baby had sickle cell carrier testing? ___ yes ___ no

Are you or the baby's father ASHKENAZI JEWISH, PENNSYLVANIA DUTCH, LOUISIANA CAJUN, OR QUEBEC FRENCH CANADIAN? ___ yes ___ no

If yes, have you or the father of the baby had Tay-Sachs carrier testing? ___ yes ___ no

Are you or the baby's father ITALIAN or GREEK? ___ yes ___ no

If yes, have you or the father of the baby had thalassemia carrier testing? ___ yes ___ no

Are you the victim of emotional or physical abuse? ___ yes ___ no

We routinely screen all OB patients for HIV, the virus that causes AIDS (HIV testing). If you are positive, treatment can reduce the risk of fetal infection. Are you agreeable to HIV Testing when other prenatal blood tests are drawn? ___ yes ___ no

Do you have any concerns not covered by the above? ___ yes ___ no

Patient Signature

Today's Date (MM/DD/YYYY)

Physician Authorization

Today's Date (MM/DD/YYYY)