Kitsap OB|GYN PLLC

ID #: _____ Provider: _____

DATE: _____

OB EDC: _____

OB CARE: _____

Patient Name: _____ Date of Birth: _____

First Day of Last Menstrual Period: _____

Religion: _____ Occupation: _____ Years of Education: _____

Father of Baby: _____ FOB Phone Number: _____

GENETIC HISTORY	**PATIENT**		**BABY'S FATHER**		
Thalassemia	Y	N	Y	N	UNKNOWN
Neural Tube Defects	Y	N	Y	N	UNKNOWN
Down's Syndrome	Y	N	Y	N	UNKNOWN
Tay-Sachs	Y	N	Y	N	UNKNOWN
Sickle Cell Disease / Trait	Y	N	Y	N	UNKNOWN
Hemophilia	Y	N	Y	N	UNKNOWN
Muscular Dystrophy	Y	N	Y	N	UNKNOWN
Cystic Fibrosis	Y	N	Y	N	UNKNOWN
Huntington Chorea	Y	N	Y	N	UNKNOWN
Mental Retardation	Y	N	Y	N	UNKNOWN
Fragile X	Y	N	Y	N	UNKNOWN
Other Genetic / Chromosomal	Y	N	Y	N	UNKNOWN
Child with other birth defect	Y	N	Y	N	UNKNOWN
More than 3 miscarriages	Y	N	Y	N	UNKNOWN
History of Stillbirth	Y	N	Y	N	UNKNOWN
Twins	Y	N	Y	N	UNKNOWN

Any NON-Prescription Drugs, Street Drugs or alcohol since last menstrual period? Y N