THE HARVEY INSTITUTE FOR HUMAN GENETICS
PRENATAL DIAGNOSTIC CENTER
6701 NORTH CHARLES STREET, SUITE #2310
BALTIMORE, MARYLAND 21204
TELEPHONE: 443-849-2536 FAX: 443-849-2708

PATIENT MEDICAL HISTORY

Your Name: ____

Baby's Father's Name: ____

A. YOUR MEDICAL HISTORY (BIRTH DEFECTS, ILLNESSES, HOSPITALIZATIONS): ____________

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B. MEDICAL HISTORY OF BABY'S FATHER ____

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C. DURING THE PREGNANCY, HAVE YOU:

	YES	NO
Taken any medications?	☐	☐
Had exposure to x-rays or radiation?	☐	☐
Had exposure to viruses or illness?	☐	☐
Had a fever or illness?	☐	☐
Consumed alcohol, tobacco, or recreational drugs?	☐	☐
Had complications such as bleeding or leaking fluid?	☐	☐

Please provide details: ____

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D. PLEASE INDICATE YOUR RACE/ETHNIC BACKGROUND. CHECK AS MANY AS APPLY:

	Yourself	Spouse/Partner
Asian	☐	☐
Black	☐	☐
Caucasian	☐	☐
Greek, Italian, Mediterranean	☐	☐
Hispanic	☐	☐
Jewish or French Canadian	☐	☐
Other	☐	☐

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Name: ____ Date: _________________________

Have you had testing through bloodwork for any disorder that is more common in your ethnic group (for example, sickle cell anemia, cystic fibrosis, Tay-Sachs disease, thalassemia?). If so, what were the results?

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E. HAVE ANY OF THE FOLLOWING OCCURRED IN YOUR FAMILY OR IN THE FAMILY OF THE BABY'S FATHER?

	YES	NO
Birth defects	☐	☐
Bleeding disorder (e.g., hemophilia)	☐	☐
Blindness	☐	☐
Blood clot/stroke/heart attack	☐	☐
Childhood or early onset cancers	☐	☐
Chromosome abnormality (e.g., trisomy)	☐	☐
Congenital kidney or liver disease	☐	☐
Cystic fibrosis	☐	☐
Deafness	☐	☐
Down syndrome	☐	☐
Dwarfism/skeletal abnormality	☐	☐
Enzyme deficiency (e.g., PKU)	☐	☐
Heart defect	☐	☐
Huntington's disease	☐	☐
Hydrocephalus	☐	☐
Infertility	☐	☐
Mental retardation/learning disability	☐	☐
Muscular dystrophy	☐	☐
Severe anemia	☐	☐
Spina bifida or anencephaly	☐	☐
Stillbirth or infant/childhood death	☐	☐
Two or more miscarriages	☐	☐

Please provide details and indicate the relationship of the affected person to you or the baby's father:

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F. ARE YOU ALLERGIC TO ANY MEDICATION(S)? **YES NO** **IF SO,WHAT**_____________

ARE YOU ALLERGIC TO LATEX? **YES NO**

G. ARE YOU AND THE BABY'S FATHER RELATED BY BLOOD (FOR EXAMPLE, ARE YOU COUSINS)? YES ☐ NO ☐

H. PLEASE PROVIDE ANY OTHER INFORMATION YOU FEEL IS RELEVANT TO THIS PREGNANCY, YOUR FAMILY HISTORY, OR THE FAMILY HISTORY OF THE BABY'S FATHER.

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