Northern Virginia Physicians to Women, Ltd.
Obstetrics & Gynecology

Date: _____

Name_____ DOB: _____ Age: _____
Last Menstrual Period (start date): _____

Have you ever been pregnant? □ Yes □ No

Dates of Delivery	Type of Delivery	Gender

Gravida: _____ Para: _____
Estimated Gestational Age in Weeks: _____ Days: _____
Are your cycles: □ Regular □ Irregular
Date of your last pap smear? _____ □ Normal □ Abnormal
What pregnancy symptoms have you experienced? _____
_____
Any major medical issues? _____

Is there a history of Jewish Ancestry?	□ Yes	□ No
Are there any cats in the home?	□ Yes	□ No
Have you ever had the Chicken Pox?	□ Yes	□ No
Are there any issues with domestic violence?	□ Yes	□ No
Were you 35 years of age or older at estimated date of conception?	□ Yes	□ No
Any history of the following:		
Thalassemia:	□ Yes	□ No
Neural Tube Defects:	□ Yes	□ No
Heart Defect:	□ Yes	□ No
Down Syndrome:	□ Yes	□ No
Tay-Sachs:	□ Yes	□ No
Canavan's Disease:	□ Yes	□ No
Sickle Cell Disease:	□ Yes	□ No
Blood Disorders:	□ Yes	□ No
Muscular Dystrophy:	□ Yes	□ No
Cystic Fibrosis:	□ Yes	□ No
Huntington's Chorea:	□ Yes	□ No
Mental retardation or Autism:	□ Yes	□ No
Other inherited genetic or chromosomal disorder:	□ Yes	□ No
Metabolic Disorder:	□ Yes	□ No
Other: _____		
Does patient or Father of Baby have a birth defect?	□ Yes	□ No
Is there a history of pregnancy loss or stillbirth?	□ Yes	□ No
Any exposure or history of exposure to TB (Tuberculosis)?	□ Yes	□ No
Any history of genital herpes in patient or partners?	□ Yes	□ No
Has there been any rash or viral illness since Last Menstrual Period?	□ Yes	□ No
Is there a history of STD?	□ Yes	□ No

Medications since Last Menstrual Period? _____
Any other exposure to discuss? _____
Is there any other pertinent information? _____