OB History Addendum

Name:______________________________________**DOB**: __________________

Name of partner or support person: ____

Name of the father of the baby (if different from above): ________________________________

Preferred pediatrician (if known): ____

Do you plan to breast or bottle feed (Circle One)? BREAST BOTTLE BOTH

Are you interested in birth classes (childbirth education, infant CPR, breastfeeding)? Yes_____No_____

Have you or your significant other traveled outside of the US within 3 months prior to or during your pregnancy?

No_____Yes_____Dates & Location(s) Traveled ____

Pregnancy History Details: (attach additional paper if needed)

Month/Year/ Duration of pregnancy	Type of delivery: vaginal, c-section, miscarriage, abortion	Baby's weight	Baby's name/sex	Place of delivery/delivering doc or midwife	Complications

Genetic/Ethnic History: Include and list all family history for yourself and father of the baby

Disease	✓ If Yes	Person Affected
Thalassemia (Italian, Greek, Mediterranean, Asian background)		
Neural Tube Defects (spina bifida, anencephaly, meningomyelocele)		
Cleft Lip or Cleft Palate		
Downs Syndrome		
Tay-Sachs		
Sickle cell disease or trait		
Heart Birth Defect (congenital heart defect)		
Hemophilia		
Developmental Delay		
Muscular Dystrophy		
Cystic Fibrosis		
Huntington's Chorea		
Mental retardation/autism		
African-American, Jewish or French Canadian Background		

Please list any additional genetic disorders or birth defects not listed above along with the person affected: