Submit by Email Print Form

Muir OB-GYN Medical Group

112 La Casa Via #200 Walnut Creek, CA 94598
(925)933-4747 (925)935-3559 fax

Pregnancy Supplement

Name:_____ Date of Birth:_____ Today's Date:_____
First Day of Last Period:_____

Baby's Father

Name:_____ Date of Birth:_____ Height:_____ Weight:_____
Race:_____ Occupation:_____Additional Phone Number:_____
Medical Conditions:_____

Risk Factors Check List

The list below contains several risk factors for having a pregnancy requiring special handling. Please check all that apply to you.

If you are:	Check Here:
35 or older by your due date	☐
Of Jewish parentage (you or your partner)	☐
Of African-American heritage (you or your partner)	☐
A smoker	☐
A caffeine user	☐
An alcohol user	☐
A cat owner	☐
A hot tub user	☐
A vegetarian	☐
A raw meat eater	☐
Taking medications other than prenatal vitamins	☐
Exposed to unusual environmental situations	☐
A past or present user of "street drugs"	☐
A herpes carrier (you or your partner)	☐
A "DES"* daughter *A medication given to your mother, during her pregnancy with you, if she was threatening to have a miscarriage	☐

Please specify medications taken since your last menstrual period:_____
_____
Alcohol, tobacco or other drugs since last period:_____
_____
_____

Genetic History
Please check any conditions that have occurred in your families

☐ **Neural Tube Defects (anencephaly, spina bifida, menigomyeloceole)**

☐ **Down's Syndrome**	☐ **Tay Sachs Disease**	☐ **Sickle Cell Disease or Trait**
☐ **Thallasemia**	☐ **Hemophilia**	☐ **Huntington's Chorea**
☐ **Muscular Dystrophy**	☐ **Mental Retardation**	☐ **Fragile X Syndrome**
☐ **Cystic Fibrosis**	☐ **Still Birth**	☐ **More than 2 Spontaneous Abortions**

Other inherited disorder:_____

Any other genetic concerns:_____

_____

Patient Signature: _____ **Date:** _____

Muir Obstetrics & Gynecologic Medical Group, Inc.

L. Sandy Hughes, III, MD, FACOG ♦ Gerald F. Katz, MD, FACOG ♦ Nadine B.Hanna, MD, FACOG
Vincent P. DiMaggio, MD ♦ Judy Jones, RN, BSN, FNP ♦ Patricia Geraghty, RN, MS, FNP
Sarah Noble, RN, MS, FNP ♦ Linda Fung Shui, RN, MSN, FNP

To: Muir OB/GYN

I hereby authorize Muir OB/GYN to release all aspects of my medical history, lab results, sonograms and on-going medical care to (name)_____ (relationship)_____ and (name)_____ (relationship)_____. Lab information excludes results of HIV and Genetic Testing, which can only be given to the patient in person.

I authorize confirmation of any appointments I have.

This authorization is valid for one year to date.

Patient Name:_____

Patient Signature:_____

Date:_____

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