Mount Sinai Doctors

ROUTINE ANATOMY SCAN MEDICAL HISTORY FORM

Name:_____ DOB: _____

Please check the following pertinent information:

OBGYN HISTORY

- abnormal Pap
- LEEP
- Cone biopsy
- Miscarriage
- Preterm Delivery
- Preterm Labor
- Full Term Delivery
- Prior Cesarean Section
- Gestational Diabetes in Prior Pregnancy
- Stillbirth
- Intrauterine Death (>22 weeks)
- Recurrent Abortion

MEDICAL HISTORY

- Congenital Heart Defect
- Other Cardiac Disease
- Renal Disease
- Hypertension
- Pre-Gestational Diabetes
- Gestational Diabetes
- Liver Disease
- Hypothyroid
- Hyperthyroid
- Autoimmune Disorder (please specify)
- Deep Vein Thrombosis/Pulmonary Embolus
- Antiphospholipid Antibody Syndrome
- Asthma
- Seizure disorder
- Other (please specify)

FAMILY HISTORY

- Mental Retardation
- Chromosomal Abnormality
- Congenital Heart Defect
- Neural Tube Defect
- Other Genetic Disorder (please specify)

CURRENT PREGNANCY

- Bleeding/Spotting 1st Trimester ***640.03***
- Bleeding/Spotting 2nd trimester ***641.93***
- Had a Subchorionic Hematoma ***656.83***
- Cervical Shortening ***647.73***
- Cerclage ***654.53***
- Abdominal Cramping ***789.00***
- Abnormal 1st or 2nd Trimester Down syndrome Screen
- Had CVS or Amniocentesis this Pregnancy ***659.63***
- Fibroid Uterus ***654.13***
- Lupus ***710.1***
- Crohn's Disease ***555.9***

LIST ANY OTHER RELEVANT INFORMATION:

Please Sign Below: I understand an ultrasound examination cannot rule out all anatomic abnormalities or genetic syndromes

_____

Signature Date