Name/Nombre: _____ Date of Birth/Fecha de Nacimiento: _____

Hospitalizations / Hospitalizaciones

Fill in the information for each time you have been in the hospital. Include any surgeries you have had on an outpatient basis
LIene cada vez que a estado en el hospital

Dates you were there? Fecha?	Reason Hospitalized? Razon?	Who was your doctor? Doctor?	What hospital were you in? Hospital?	
Medication Name Nombre de Medicamento	Prescribing Doctor's Name Doctor que lo receto	Reason for taking the medication Razon	Dosage Dosis	How often? Cada Cuando?

GENETIC SCREENING & TERATOLOGY COUNSELING / DETECCION GENETICO Y CONSEJERIA

Includes patient, baby's father, or anyone in either family / incluya paciente, padre del bebe y familiares

1. PATIENTS AGE 35 YEARS OR OLDER AS OF ESTIMATED DATE OF DELIVERY PACIENTE TENDRA MAS DE 35 ANOS AL DAR ALUZ	☐ YES / SI ☐ No
2. THALASSEMIA (ITALIAN, GREEK, MEDITERRANEAN OR ASIAN BACKGROUND) MCV<80 ORIGINARIOS DE IT ALIA, ASIA, MERITERRANIO	☐ YES / SI ☐ No
3. NEURAL TUBE DEFECT (MENINGOMYELOCELE, SPINA BIFIDA OR ANENCEPHALY DEFECTO NEURO (ESPINEBIFERA-EJEMPLO)	☐ YES / SI ☐ No
4. CONGENITAL HEART DEFECT / DEFECTO CONGENITAL DEL CORAZON)	☐ YES / SI ☐ No
5. DOWN SYNDROME/ SYNDROMA DE DOWNS	☐ YES / SI ☐ No
6. TAY-SACHS (EG. JEWISH, CAJUN, FRENCH CANADIAN) / TAY-SACHS (JUDIOS, CANADIENSES)	☐ YES / SI ☐ No
7. CANAVAN DISEASE / ENFERMEDAD CANAVAN	☐ YES / SI ☐ No

8. SICKLE CELL DISEASE OR TRAIN (AFRICAN) / ENFERMEDAD DE CELULA SICKLE	☐ YES / Sl ☐ No
9. HEMOPHILIA OR OTHER BLOOD DISORDERS / DESORDEN DE SANGRE o HEMOFILIA	☐ YES / Sl ☐ No
10. MUSCULAR DYSTROPHY / DISTROFIA MUSCULAR	☐ YES / Sl ☐ No
11. CYSTIC FIBROSIS / FIBROSIS CISTICO	☐ YES / Sl ☐ No
12. HUNTINGTON'S CHOREA / CHOREA DE HUNTINGTON	☐ YES / Sl ☐ No
13. MENTAL RETARDATION or AUTISM / RETARDACION MENTAL o AUTISTA a. If yes, was person tested for Fragile X? / esa persona a sido examinada para Fragile X	☐ YES / Sl ☐ No
14. OTHER INHERITED GENETIC OR CHROMOSOMAL DISORDER DESORDEN HEREDITARIA CHROMOSONAL o GENETICO	☐ YES / Sl ☐ No
15. MATERNAL MEABOLIC DISORDER (TYPE 1 DIABETES, PKU) DESOROEN METABOLICO MATERNAL (DIABETES)	☐ YES / Sl ☐ No
16. PATIENT OR BABY'S FATHER HAD A CHILD WITH BIRTH DEFECTS NOT LISTED ABOVE PACJENTE/PADRE DE BEBE TUVO UN BEBE CON DEFECTOS	☐ YES / Sl ☐ No
17. RECURRENT PREGNANCY LOSS OR STILLBIRTH I PERDIDAS DE EMBARAZO RECORRIENTES	☐ YES / Sl ☐ No
18. MEDICATIONS {INCLUDING SUPPLEMENTS, VITAMINS, HERBS OR OTC DRUGS) ILLICIT/RECREATIONAL DRUGS/ALCOHOL SINCE LAST MENSTRUAL PERIOD / MEDICAMENTOS (VITAMINAS, HJERBAS, DROGAS, ALCOHOL DESDE SU ULTIMA MENSTRUACION)	☐ YES / Sl ☐ No
19. ANY OTHER / OTRA COSA	☐ YES / Sl ☐ No