1. Last Name			First Name							MI
2. Patient Number										
3. Date of Birth (MM/DD/YYYY)										
			Month		Day			Year		

4. Race ☐ American Indian or Alaska Native ☐ Asian
☐ Black/African American ☐ Native Hawaiian/Other Pacific Islander
☐ Unknown ☐ White ☐ Other _____

5. Ethnic Origin ☐ Hispanic Cuban ☐ Hispanic Mexican American
☐ Hispanic Other ☐ Hispanic Puerto Rican
☐ Not Hispanic/Latino ☐ Unreported

6. Gender ☐ Female ☐ Male

7. County of Residence

N.C. Department of Health and Human Services
Division of Public Health
Women, Infant, and Community Wellness Section

MATERNAL HEALTH HISTORY — Part B

(See Instructions)

GENETIC / TERATOLOGY HISTORY — Circle If More Then One Response In Item Number Applies

Includes Patient, Infant's Father, or Anyone in Either Family with:

(Detail positive findings below in comments / counseling section)

	Patient	Family	Father of Infant		Patient	Family	Father of Infant
1. Patient's Age ≥ 35 Years				12. Tay-Sachs			
2. Down Syndrome				13. Huntington Chorea			
3. Cystic Fibrosis				14. Canavan, Dysautonomia			
4. Sickle Cell Disease				15. Metabolic Disorder (ex: Type I Diabetes, PKU)			
5. Sickle Cell Trait				16. Muscular Dystrophy			
6. Congenital Heart Defect				17. Patient or FOB had a Child with Birth Defects			
7. Neural Tube Defect (spina bifida, meningomyelocele or anencephaly)				18. Recurrent Pregnancy Loss, or a Stillbirth			
8. Thalassemia				19. Other Inherited Genetic or Chromosomal Disorder			
9. Intellectual Disability If yes, was person tested for Fragile X?				20. Any medications either prescribed or non-prescribed since your last Menstrual Period? Name/ Type_____			
10. Hemophilia or other blood disorders				21. Occupational/Environmental Hazards (i.e., second hand smoking/electronic nicotine devices/lead exposure)			
11. RH sensitized				22. Has patient ever been evaluated by a genetic counselor or tested for Cystic Fibrosis or Spinal Muscular Atrophy carrier status? (Yes or No) *	YES	NO	*If no, refer to genetic counseling or provide carrier testing.

COMMENTS / COUNSELING: _____

INFECTION/IMMUNIZATION HISTORY — Circle All That Apply In Each Item Number

(Detail positive findings below in comments / counseling section)

	YES	NO		YES	NO
1. High Risk for Hepatitis A? Immunized ☐ Yes ☐ No **Date**_____			8. Exposure to or History of Rubella? Immunized ☐ Yes ☐ No **Date**_____		
2. High Risk for Hepatitis B? Immunized ☐ Yes ☐ No **Date**_____			9. Exposure to or History of Varicella Zoster (Chicken Pox)? Immunized ☐ Yes ☐ No **Date**_____		
3. High Risk for Hepatitis C?			10. Exposure to or History of Mumps? Immunized ☐ Yes ☐ No **Date**_____		
4. Lives with Someone with TB or Exposed to TB			11. Rash or Viral Illness since Last Menstrual Period		
5. Patient or Partner has History of Genital Herpes			12. History of HIV and/or GC, Chlamydia, HPV, Syphilis, and/ or other Sexually Transmitted Infections		
6. Exposure to or History of Rubeola? Immunized ☐ Yes ☐ No **Date**_____			13. History of Toxoplasmosis and/or Cytomegalovirus		
7. History of SARS-CoV-2 Vaccination 1st Dose_____ 2nd Dose_____ Booster_____			14. History of a Newborn with Group B Streptococcus (GBS) (not the patient, but the newborn diagnosed with GBS)		

COMMENTS / COUNSELING: _____

Signature:_____ Date: _____

Interpreter Used ☐ N/A ☐ No ☐ Yes Interpreter Name _____