1. Last Name	First Name	MI	N.C. Department of Health and Humar Division of Public Health
2. Patient Number			Women, Infant, and Community Wellne
3. Date of Birth (MM/DD/YYYY)	 Month Day	Year	Women, man, and community wears
4. Race ☐ American Indian or Ala ☐ Black/African American ☐ Unknown ☐ White [☐ Native Hawaiian/Oth	er Pacific Islander	MATERNAL HEALTH HISTO (See Instructions)
	an □ Hispanic Mexicar er □ Hispanic Puerto R Latino □ Unreported		
6. Gender □ Female □ Male			
7. County of Residence			
OENETIO / TEDATOL OO	V. I II O T O D V. O :		en One Response In Item Number Applies

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

MATERNAL HEALTH HISTORY — Part B

1. Patient's Age 2 35 Years		Patient	Family	Father of Infant		Patient	Famil v	Fathe Infant	r of	
2. Down Syndrome 1.3. Huntington Chorea	1. Patient's Age ≥ 35 Years				12. Tay-Sachs		,			
15. Metabolic Disarder (ex: Type Disarder (ex:										
5. Sickle Cell Trait 6. Congenital Heart Defect 7. Neural Tube Defect (spina bidia, meningomyelocele or anencephaly) 8. Thalassemia 9. Intellectual Disability (Tyes, was person tested for Fragile X? 10. Hemophilia or other blood disorders 11. RH sensitized 12. Any medications either prescribed or non-prescribed since your last Menstrual Period Provided Sensitive findings below in comments / counseling section) 11. RH sensitized 12. Has patient ever been evaluated by YES NO agencial Muscular Autophy carrier status? (Yes or No) ** INFECTION/IMMUNIZATION HISTORY — Circle All That Apply In Each Item Number (Detail positive findings below in comments / counseling section) 11. High Risk for Hepatitis B? Immunized Yes No Date 10. Exposure to or History of Rubella? Immunized Yes No Date 10. Exposure to or History of Mumpa? Immunized Yes No Date 10. Exposure to or History of Mumpa? Immunized Yes No Date 11. Rash or Viral Illness since Last Menstrual Period 12. History of History of Rubella? Immunized Yes No Date 11. Rash or Viral Illness since Last Menstrual Period 15. Patient or Partner has History of Genital Herpes 12. History of History of Rubella? Immunized Yes No Date 15. Patient or Partner has History of Genital Herpes 16. Exposure to or History of Mumpa? Immunized Yes No Date 17. Rash or Viral Illness since Last Menstrual Period Yes No Date 18. History of History of Rubella? Immunized Yes No Date 19. Exposure to or History of Mumpa? Immunized Yes No Date 19. Exposure to or History of Mumpa? Immunized Yes No Date 19. Exposure to or History of Mumpa? Immunized Yes No Date 19. History of Hiv and/or GC, Chlamydia, HPV, Syphilis, and/or or other Sexually Transmitted Infections 19. History of SARS-CoV-2 Vaccination 19. Light North North History of Rubella? Immunized Yes No Date 19. History of SARS-CoV-2 Vaccination 19. History of SARS-CoV-2 Vaccination 19. History of	3. Cystic Fibrosis				14. Canavan, Dysautonomia					
17. Patient or FOB had a Child with Birth Defects 17. Patient or FOB had a Child with Birth Defects 18. Recurrent Pregnancy Loss, or a Stillbirth Defects 18. Recurrent Pregnancy Loss, or a Stillbirth Defects 19. Other Inherited Genetic or Chromosomal Disorder 19. Other Inherited Genetic or Chromosomal Disorder 20. Any medications either prescribed or non-prescribed since your last Menstrual Period? Name/ Type 21. Occupational/Environmental Hazards (i.e., second hand smoking/electronic nicotine disorders 22. Has patient ever been evaluated by YES NO History Carrier status? (Yes or No) 17. Page 19. Other Loss or Spinal Muscular Atophy carrier status? (Yes or No) 19. Other Loss or Spinal Muscular Atophy carrier status? (Yes or No) 19. Other Loss or Spinal Muscular Atophy carrier status? (Yes or No) 19. Other Loss or Spinal Muscular Atophy carrier status? (Yes or No) 19. Other Loss or Spinal Muscular Atophy carrier status? (Yes or No) 19. Other Loss or Spinal Muscular Atophy carrier status? (Yes or No) 19. Other Loss or Spinal Muscular Atophy carrier status? (Yes or No) 19. Other Loss or Spinal Muscular Atophy carrier status? (Yes or No) 19. Other Loss or Spinal Muscular Atophy carrier status? (Yes or No) 19. Other Loss or Spinal Muscular Atophy carrier status? (Yes or No) 19. Other Loss or Spinal Muscular Atophy carrier status? (Yes or No) 19. Other Loss or Spinal Muscular Atophy carrier status? (Yes or No) 19. Other Loss or Spinal Muscular Atophy carrier status? (Yes or No) 19. Other Loss or Spinal Muscular Atophy carrier status? (Yes or No) 19. Other Loss or Spinal Muscular Atophy carrier status? (Yes or No) 19. Other Loss or Spinal Muscular Atophy carrier status? (Yes or No) 19. Other Loss or Spinal Muscular Atophy carrier status? (Yes or No) 19. Other Loss or Spinal Muscular Atophy carrier status? (Yes or No) 19. Other Loss or Spinal Muscular Atophy carrier status? (Yes or No) 19. Other Loss or Spinal Muscular Atophy carrier status? (Yes or No) 19	4. Sickle Cell Disease									
Birth Defects Birth Defect	5. Sickle Cell Trait				16. Muscular Dystrophy					
blifida, meningomyelocele or anencephaly) 8. Thalassemia 9. Intellectual Disability If yes, was person tested for Fragile X? 10. Hemophilia or other blood disorders 11. RH sensitized 22. Has patient ever been evaluated by a genetic counselor or testing person deside accounselor or tested for Cystic Fibrosis or Spinal Muscular Atrophy 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.) 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.) 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.) 11. High Risk for Hepatitis A? 12. Immunized Yes No. Date	6. Congenital Heart Defect									
9. Intellectual Disability If yes, was person tested for Fragile X? 10. Hempohilia or other blood disorders 11. RH sensitized 12. High Risk for Hepatitis R? 13. High Risk for Hepatitis R? 14. Lives with Someone with TB or Exposed to TB 15. Patient or Partner has History of Rubeola? 16. Exposure to r History of Rubeola? 17. History of SARS-CoV-2 Vaccination 18. Counselings 19. Any medications either prescribed or non-prescribed since your last Menstrual Period? Name/ Type 19. Any medications either prescribed or non-prescribed or non-prescribed or non-prescribed since your last Menstrual Period? Name/ Type 21. Occupational/Environmental Hazards (i.e., second hand smoking/electronic nicotine devices/lead exposure) 22. Has patient ever been evaluated by YES NO Plana, refer to seat smoking/electronic nicotine devices/lead exposure) 22. Has patient ever been evaluated by YES NO Plana, refer to seat smoking/electronic nicotine devices/lead exposure) 22. Has patient ever been evaluated by YES NO Plana, refer to seat smoking/electronic nicotine devices/lead exposure) 22. Has patient ever been evaluated by YES NO Plana, refer to seat sometiment of Cystic Fibrosis or Spinal Muscular Atrophy Cystic Rubeila? 22. Has patient ever been evaluated by YES NO Plana, refer to seat sometiment of Cystic Fibrosis or Spinal Muscular Atrophy Cystic Rubeila? 23. High Risk for Hepatitis A? 24. Lives with Someone with TB or Exposed to TB 25. Patient or Partner has History of Genital Herpes 26. Exposure to or History of Mumps? 27. History of Toxoplasmosis and/or Cytomegalovirus 28. History of SARS-CoV-2 Vaccination 29. History	bifida, meningomyelocele or									
If yes, was person tested for Fragile X? 10. Hemophilia or other blood disorders 11. RH sensitized 12. Occupational/Environmental Hazards (i.e., second hand smoking/electronic nicoline devices/fieled exposure) 12. Has patient ever been evaluated by YES NO "If no, refer to genet agenetic counselor or tested for Cystic Fibrosis or Spinal Muscular Atrophy carrier status? (Yes or No) " INFECTION/IMMUNIZATION HISTORY — Circle All That Apply In Each Item Number (Detail positive findings below in comments / counseling section) 1. High Risk for Hepatitis A? YES NO 8. Exposure to or History of Rubella? Immunized Pes No Date Pimmunized Pes	8. Thalassemia									
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Somments / Counseling or provident of Epirosis or Spinal Muscular Atrophy carrier testing. Comments / Counseling section					Hazards (i.e., second hand smoking/electronic nicotine devices/lead exposure)					
INFECTION/IMMUNIZATION HISTORY — Circle All That Apply In Each Item Number (Detail positive findings below in comments / counseling section) 1. High Risk for Hepatitis A? YES NO 8. Exposure to or History of Rubella? YES NO Immunized Yes No Date 9. Exposure to or History of Varicella Zoster (Chicken Pox)? Immunized Yes No Date 9. Exposure to or History of Mumps? Immunized Yes No Date 9. Exposure to or History of Mumps? Immunized Yes No Date 9. Exposure to or History of Mumps? Immunized Yes No Date 9. Exposure to or History of Mumps? Immunized Yes No Date 9. In Rash or Viral Illness since Last Menstrual Period 9. Exposure to or History of HIV and/or GC, Chlamydia, HPV, Syphilis, and/or or other Sexually Transmitted Infections 9. History of Rubeola? In History of Toxoplasmosis and/or Cytomegalovirus 13. History of SARS-CoV-2 Vaccination 14. History of a Newborn with Group B Streptococcus (GBS) (not the patient, but the newborn diagnosed with GBS)	I1. RH sensitized				22. Has patient ever been evaluated by a genetic counselor or tested for Cystic Fibrosis or Spinal Muscular Atrophy YES NO *If no, counse carrier				seling or provid	
Immunized Yes No Date	OMMENTS / COUNSELING:				Fibrosis or Spinal Muscular Atrophy			carrier testing	•	
2. High Risk for Hepatitis B?	INFECTION/IMMUNIZATIO				Fibrosis or Spinal Muscular Atrophy carrier status? (Yes or No) * at Apply In Each Item Number			carrier testing		
Chicken Pox)? Immunized Yes No Date 10. Exposure to or History of Mumps? Immunized Yes No Date 11. Rash or Viral Illness since Last Menstrual Period Yes Separation or other Sexually Transmitted Infections 12. History of HIV and/or GC, Chlamydia, HPV, Syphilis, and/or other Sexually Transmitted Infections 13. History of Toxoplasmosis and/or Cytomegalovirus 14. History of a Newborn with Group B Streptococcus (GBS) (not the patient, but the newborn diagnosed with GBS) OMMENTS / COUNSELING:	INFECTION/IMMUNIZATIO (Detail positive findings below in		/ counseli	ng section	Fibrosis or Spinal Muscular Atrophy carrier status? (Yes or No) * at Apply In Each Item Number					
3. High Risk for Hepatitis C? 4. Lives with Someone with TB or Exposed to TB 5. Patient or Partner has History of Genital Herpes 6. Exposure to or History of Rubeola? Immunized Yes No Date 7. History of SARS-CoV-2 Vaccination 1st Dose Partner has Dose No Date No	INFECTION/IMMUNIZATIO (Detail positive findings below in 1. High Risk for Hepatitis A?	n comments	/ counseli	ng section	Fibrosis or Spinal Muscular Atrophy carrier status? (Yes or No) * at Apply In Each Item Number 8. Exposure to or History of Rubella?					
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ignature:Date:Date:	INFECTION/IMMUNIZATIO (Detail positive findings below in 1. High Risk for Hepatitis A?	exposed to T f Genital Herpola? Pate	B pes	ring section	at Apply In Each Item Number 8. Exposure to or History of Rubella? Immunized Yes No Date 9. Exposure to or History of Varicella (Chicken Pox)? Immunized Yes No Date 10. Exposure to or History of Mumps Immunized Yes No Date 11. Rash or Viral Illness since Last M 12. History of HIV and/or GC, Chlamy or other Sexually Transmitted Info	Zoster ? enstrual Per /dia, HPV, Sections Cytomegalo	Syphilis, an	YES dd/	NO	