Harvard Family Physicians, P.C.

Patient Screening History

Robert "Bob" Aikman, M.D.
Angela Christy-Lovell, D.O.
Shelley D. Shoun, M.D.

Patient Name:_____

Father of Baby:_____

Many families care rare genetic problems. Those families usually recognize the name of such a disease. Please tell us if you or the biological father of the baby has any of the following diseases in your families.

Circle all that apply:

Birth Defects	Hydrocephalus (water in the brain)	Infant or Childhood Deaths
Childhood Blindness	Polycystic Kidney Disease	Congenital Heart Disease
Down's Syndrome (Mongolism)	Hemophilia (free bleeder)	Dwarfism
Childhood Deafness	Huntington's Chorea	Spina Bifida (open spine)
Mental Retardation	Cystic Fibrosis	Galactosemia
Childhood Heart Disease	Muscular Dystrophy	Cleft Lip or Plate

Yes	No	
_____	_____	Do you know of any other genetic diseases in your family?
_____	_____	Are you and the father of the baby blood relatives?
_____	_____	Have you or the father of the baby lived in Haiti, Africa, or Southeast Asia?
_____	_____	Do you or the father of the baby use street drugs in the veins?
_____	_____	Have you or the father of the baby had a blood transfusion?
_____	_____	Have you or the father of the baby been in prison?
_____	_____	Have you or the father of the baby had sex with a homosexual?
_____	_____	Have you or the father of the baby had serum hepatitis or AIDS?
_____	_____	Would you or the father of the baby like to have a test for hepatitis or AIDS?
_____	_____	Have you had herpes?
_____	_____	Do you suffer physical or mental abuse?
_____	_____	Have you previously had twins?

Please list any other medical conditions that are common in your family (Diabetes, Heart Trouble, etc.).

_____

If you or the father of the baby is in the following categories, please respond:

Yes	No	
_____	_____	Black/Indian – have you had sickle cell testing?
_____	_____	Jewish – have you had Tay Sachs disease testing?
_____	_____	Italian/Greek/Southeast Asian – have you had Thalassemia testing?

List any problems you have had in this or any other pregnancy that you would like to discuss with the doctor:

_____

_____

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Physician Signature **Date**