

June 09



Response Sheet

CODERFax

To: **Barbara Suter** From: _____
 Fax: **585-424-1469** Pages: _____
 Phone: **585-758-7811** Date: _____

Prenatal History

Pregnancy History (Twin B)					
Previous Live Births:		Previous Spontaneous Terminations:		Previous Induced Terminations:	Total Prior Pregnancies:
Now Living None or Number	Now Dead None or Number	Less than 20 weeks None or Number	20 weeks or more None or Number	None or Number	None or Number
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
First Live Birth: (MM/YYYY)	Last Live Birth: (MM/YYYY)	Last Other Pregnancy Outcome: (MM/YYYY)			
Prenatal Care					
Risk Factors in this Pregnancy					
___ None ___ Unknown at this time Select all that apply ___ Prepregnancy Diabetes ___ Gestational Diabetes ___ Prepregnancy Hypertension ___ Gestational hypertension ___ Other serious chronic illnesses ___ Previous Preterm Births ___ Abruptio Placenta ___ Eclampsia ___ Other poor pregnancy outcomes ___ Prelabor Referred for High Risk Care ___ Other Vaginal Bleeding ___ Previous Low Birthweight Infant ___ Pregnancy resulted from infertility treatment (if yes, check all that apply) ___ Fertility-enhancing drugs, artificial or intrauterine insemination ___ Assisted reproductive technology (e.g. IVF, GIFT) Number of Embryos Implanted: (if applicable)					
Congenital Anomalies					
<input type="checkbox"/> None of the listed <input type="checkbox"/> Unknown at this time Diagnosed Prenatally? If Yes, please indicate all methods used:					
Yes No <input type="checkbox"/> <input type="checkbox"/>	Anencephaly	Yes No <input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> Level II Ultrasound <input type="checkbox"/> MSAFP / Triple Screen <input type="checkbox"/> Amniocentesis <input type="checkbox"/> Other <input type="checkbox"/> Unknown		
Yes No <input type="checkbox"/> <input type="checkbox"/>	Meningomyelocele/Spina Bifida	Yes No <input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> Level II Ultrasound <input type="checkbox"/> Other <input type="checkbox"/> Unknown		
Yes No <input type="checkbox"/> <input type="checkbox"/>	Cyanotic Congenital Heart Disease	Yes No <input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> Level II Ultrasound <input type="checkbox"/> Other <input type="checkbox"/> Unknown		
Yes No <input type="checkbox"/> <input type="checkbox"/>	Congenital Diaphragmatic Hernia	Yes No <input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> Level II Ultrasound <input type="checkbox"/> Other <input type="checkbox"/> Unknown		
Yes No <input type="checkbox"/> <input type="checkbox"/>	Omphalocele	Yes No <input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> Level II Ultrasound <input type="checkbox"/> Other <input type="checkbox"/> Unknown		