Sonic Healthcare
**Reproductive Health**
Prenatal

# Prenatal Patient History Form

**ALL FIELDS REQUIRED**

## PATIENT INFORMATION

Name of Patient: _____ Date of Birth: _____

Provider: _____ Account #: _____

## Non-Invasive Prenatal Screening (NIPS)

**Number of Fetuses:** ◯ (S)ingleton ◯ (T)wins **Maternal Weight (lbs):** _____ **Maternal Height (in):** _____

**Estimated Date of Delivery (EDD):** ____/____/____

**IVF Pregnancy:** ◯ Y ◯ N **Patient/donor egg retrieval age:** _____ years

## Carrier Screening

**Patient Ethnicity:** ◯ African American (AA) ◯ Caucasian (W) ◯ Hispanic (H) ◯ Asian (AS)
◯ Jewish (Ashkenazi) (J) ◯ Other (O): _____ ◯ Not Specified (NS)

**Indication:** ◯ Abnormal US (US) ◯ Egg/Sperm Donor (DO) ◯ Consanguinity (CO) ◯ Infertility (IN)
◯ Partner Known Carrier (PC) ◯ Patient Known Carrier (PT) ◯ Family History (HX)

**Family History Present:** ◯ Y ◯ N **If Yes, Indicate Relative:**

◯ Sibling ◯ Parent ◯ Grandparent ◯ Aunt/Uncle ◯ Niece/Nephew ◯ Cousin

**Relative is:** ◯ Affected by Or ◯ Carrier of _____

**Is patient or partner pregnant?** ◯ Patient ◯ Partner ◯ Neither

SONIC HEALTHCARE USA

**Sonic Healthcare USA**
12357-A Riata Trace Parkway, Suite 210
Austin, TX 78727

**www.SonicReproductiveHealth.com**