Prenatal Genetic Screening Questionnaire

Name _________________________________________ Medical Record # _____________

Date of birth __________________ How old will you be when the baby is born? __________

Family and Patient History
1. Is your family or your baby’s father’s family...
   a. From Southeast Asia, Taiwan, China, or the Philippines? No Yes
   b. From Italy, Greece, or the Middle East? No Yes
   c. From Africa or African-American (Black)? No Yes
   d. Central Eastern European (Ashkenazi) Jewish? No Yes
   e. Cajun or French Canadian? No Yes

2. Have you or the baby’s father or anyone in either of your families ever had any of the following disorders?
   a. Down syndrome No Yes
   b. Other chromosomal abnormalities No Yes
   c. Neural tub defect (spina bifida) No Yes
   d. Bleeding disorder (hemophilia) No Yes
   e. Cystic fibrosis No Yes
   f. Sickle Cell No Yes
   g. Thalassemia No Yes
   h. Tay-Sachs/Canavan No Yes
   i. Neurofibromatosis No Yes
   j. Muscular dystrophy No Yes
   k. Nerve or muscle disorder No Yes
   l. Bone or skeletal disorder No Yes
   m. Polycystic kidney disease No Yes
   n. Heart defect (at birth) No Yes
   o. Cleft lip/palate No Yes

3. Are you and the baby’s father related by blood; for example, cousins? ............................................

4. Do you or the baby’s father have any close relatives* with mental retardation?..........................

5. A. Do you, the baby’s father, or a close relatives* in either of your families have a genetic condition or chromosomal abnormality not listed above? ............................................
   B. Do you, the baby’s father, or a close relatives* in either of your families have a birth defect no listed above?......................................................................................................
   C. Do you, the baby’s father, or a close relatives* in either of your families have a serious medical problem that you are concerned about?....................................................................

6. A. Have you or the baby’s father had a baby who died shortly after birth or in the first year?................................................................................................................... ......
   B. Have you or the baby’s father had a stillborn child, or two or more first trimester spontaneous pregnancy losses? ..........................................................................................

7. Excluding vitamins and iron, have you taken any medications, street drugs, or alcohol since being pregnant or since your last menstrual period? .................................................................

8. Do you have diabetes? ......................................................................................................................

9. Have you had the Expanded AFP Screening test?...........................................................................

10. If yes to any questions above, please explain: ____________________________________________________________________________
    ____________________________________________________________________________

    Complete by _________________________________ Date _____________________

    Reviewed by _________________________________ Date _____________________

* Close relative is a biologic child, mother, father, sister, brother, aunt, uncle, or grandparent