Prenatal Screening Questionnaire

Filling out and printing this form prior to an appointment with a geneticist or genetic counselor would be helpful for the specialist.

Father of the Pregnancy

Name_____

DOB (00/00/00)_____ Age _____

Ethnic Origin / Religion_____

Occupation_____

Mother of the Pregnancy

Name_____

DOB (00/00/00)_____ Age _____

Ethnic Origin / Religion_____

Occupation_____

Family and Patient History
Does your family or the father of the baby's family have the following ethnic background:

Yes No
_____ _____ Southeast Asia, Taiwan, China, or the Philippines

_____ _____ Italy, Greece, or the Middle East

If yes to the previous two questions, have you or your partner been tested for thalassemia? Yes_____No_____

Yes No

_____ _____ Eastern European (Ashkenazi) Jewish

_____ _____ French Canadian

If yes to the previous two questions, have you or your partner been tested for Tay Sachs? Yes_____No_____

Yes No

_____ _____ African American, African, or Black

If yes to the previous question, have you or your partner been tested for sickle cell anemia? Yes_____No_____

Have you, the baby's father, or anyone in either of your families ever had any of the following?
If "yes", please explain at the bottom in the space provided:

Yes	No	
_____	_____	Down Syndrome
_____	_____	Other Chromosome Abnormalities
_____	_____	Neural Tube Defect (e.g. spina bifida, anencephaly)
_____	_____	Hemophilia or Other Bleeding Disorders
_____	_____	Cystic Fibrosis
_____	_____	Sickle Cell Anemia
_____	_____	Thalassemia(Mediterranean anemia)
_____	_____	Tay Sach's Disease
_____	_____	Muscular Dystrophy
_____	_____	Neurofibromatosis
_____	_____	Huntington's Disease
_____	_____	Other Nerve, Muscle or Seizure Disorder (e.g. epilepsy)
_____	_____	Phenylketonuria (PKU)
_____	_____	Kidney Disease
_____	_____	Heart Defect (from birth)
_____	_____	Cleft Lip and/or Cleft Palate
_____	_____	Limb Defects (extra or missing digits, malformed arms, legs, hands or feet)
_____	_____	Deafness / Early Onset Hearing Loss
_____	_____	Blindness / Early Onset Vision Loss
_____	_____	Diabetes
_____	_____	Cancer before age 50
_____	_____	Heart Attack before age 40
_____	_____	Do you or the baby's father have any relatives with mental retardation or developmental delay?

Yes **No**

_____ _____ Does anyone in either of your families have a genetic defect, or chromosome abnormality not listed above?

_____ _____ Have you or the baby's father had a baby that died shortly after birth or in the first year?

_____ _____ Have you or the baby's father had a stillborn child, or three or more first trimester miscarriages?

_____ _____ Are you and the baby's father blood-related in any way (i.e., cousins, uncle-niece, etc.)?

_____ _____ Is there any other family history that you have concerns about?

Pregnancy History

During this pregnancy, have you had any of the following? If "yes", please describe, including dates, if known, in the space provided at the bottom:

Yes **No**

_____ _____ Uterine cramping, vaginal bleeding (spotting) or vaginal leakage of fluid

_____ _____ Infections, rashes, or other illness, fever over 101 degrees

_____ _____ X-rays, hospitalizations, or surgery

_____ _____ Cigarettes, alcoholic beverages, or "street" drugs

_____ _____ Ultrasound ("sonogram")

_____ _____ Occupational, chemical, or other exposures

_____ _____ Prescription or non-prescription medications

_____ _____ Prenatal vitamins

Comments from above

_____

_____

_____

_____

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_____

My signature below indicates that the above family and pregnancy history information provided is complete and correct.

_____ _____

Signature of person completing form Today's date

For office use only

G_____ P_____ Sab_____ Tab_____ St.Bth._____ Ectopic_____ Other _____

LMP_____ Wks. Gestation_____ EDC _____

Plan/Indications:

_____

_____

_____

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_____
Geneticist/Genetic Counselor