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:

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

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
_____________________________________________________________________________
_____________________________________________________________________________
_____________________________________________________________________________
_____________________________________________________________________________
_____________________________________________________________________________

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:

_____________________________________________________________________________
_____________________________________________________________________________
_____________________________________________________________________________
_____________________________________________________________________________
_____________________________________________________________________________

_________________________________
Geneticist/Genetic Counselor