

Genetic Family History & Pregnancy Questionnaire

The following questions will help evaluate the health of your unborn baby. Your answers may indicate that certain tests are appropriate. Please answer all questions as completely as possible. The better the information you provide, the better service we can give you. All information will be kept confidential.

Patient's name _____ Date of Birth _____ Age _____ Today's Date _____
 Total # of pregnancies _____ # of living children _____ Last Menstrual Period _____ Due Date _____ Allergies _____
 Your Occupation _____ Your Current Weight _____ Your Height _____ Referring Doctor _____
 Name of father of baby _____ Date of Birth _____ His Occupation _____
 Was an egg donor used for this pregnancy? _____ What is the age of the egg donor? _____ Are you a blood relative to father of your baby? _____

Are you or the father of the baby from any of these ethnic backgrounds?

- Chinese, Asian Indian, Taiwanese, Filipino, Korean or Southeast Asian-----
- Italian, Greek, Middle Eastern or Spanish-----
- Jewish, French Canadian or Cajun-----
- N. European Caucasian or S. European Caucasian-----
- Black-----

Patient
 Yes No
 Yes No
 Yes No
 Yes No
 Yes No
 Yes No

Father of Baby
 Yes No
 Yes No
 Yes No
 Yes No
 Yes No

Have you, the father of your baby, or anyone in your families ever had the following conditions?

- neurofibromatosis Yes No Polycystic kidney disease Yes No Down Syndrome Yes No
- Other chromosome problem Yes No Huntington disease Yes No Cystic fibrosis Yes No
- mental retardation or autism Yes No heart defect at birth Yes No cleft lip/cleft palate Yes No
- Spina bifida (open spine) Yes No baby who died at birth or within first year Yes No
- Anencephaly (opening in head/brain) Yes No stillborn or 2 or more pregnancy losses Yes No
- Bleeding disorder, like hemophilia Yes No any other medical condition or surgery Yes No
- any birth defect not listed here Yes No Muscular dystrophy/neuromuscular disease Yes No
- any other inherited (genetic) condition Yes No Skeletal disorder, like dwarfism Yes No

IF YES, GIVE DETAILS: _____

During this pregnancy have you had _____

- medications (**EXCLUDING prenatal vitamins and iron**) Yes No spotting, bleeding, other complications Yes No
- recreational drugs Yes No diabetes, PKU or lupus Yes No
- alcoholic drinks Yes No a multiple marker blood screening test Yes No
- exposure to X-rays Yes No rashes, infectious diseases, high fevers Yes No

IF YES, GIVE DETAILS: _____