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?

	No	Yes		No	Yes
a. Down syndrome	☐	☐	h. Tay-Sachs/Canavan	☐	☐
b. Other chromosomal abnormalities	☐	☐	i. Neurofibromatosis	☐	☐
c. Neural tub defect (spina bifida)	☐	☐	j. Muscular dystrophy	☐	☐
d. Bleeding disorder (hemophilia)	☐	☐	k. Nerve or muscle disorder	☐	☐
e. Cystic fibrosis	☐	☐	l. Bone or skeletal disorder	☐	☐
f. Sickle Cell	☐	☐	m. Polycystic kidney disease	☐	☐
g. Thalassemia	☐	☐	n. Heart defect (at birth)	☐	☐
			o. Cleft lip/palate	☐	☐

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*