Women's Specialty and Fertility Center

Prenatal Genetics Questionnaire

Patient Name: _____ Date of Birth: _____Date: _____

Please answer the following questions to the best of your ability. Your answers to the following questions will help us to recognize some potential problems which might affect the health of our unborn baby. For some of the problems there are tests available with which to evaluate the baby's health before birth.

1. Certain genetic diseases are more common in certain ethnic group:
   a.) Are either you or the baby's father black? Yes No
   b.) Have you both been tested to see if you have the sickle trait (sickle cell anemia carrier)? Yes No
   c.) If yes, has testing shown that both of you have sickle trait? Yes No
   d.) Are either you or the baby's father of Eastern European Jewish descent (Ashkenazi)?
   Yes No
   e.) Have you both been tested to see if you are Tay-Sachs carriers? Yes No
   f.) If yes, did the test results show that both of you are carriers? Yes No
   g.) Are you both of Asian or Mediterranean (Greek, Italian, etc.) descent? Yes No

2. Have you or your baby's father had a previous child or a brother or a sister with Down Syndrome or other chromosome abnormality? Yes No

3. Were you, the baby's father, any of your children or a close relative born with spina bifida (open spine) or anencephaly (no brain)? Yes No

4. Have you had a previous child, brother, father or uncle with or does baby's father have: Yes No
   a) Hemophilia or bleeding disorders
   b) Muscular Dystrophy
   c) Hydrocephalus (water on the brain)
   d) Cystic Fibrosis

5. Do you or the baby's father have a birth defect, or have you had a stillborn or live baby with a birth defect or a baby who died in the first year of life? Yes No

   If yes, describe the birth defect or cause of death. _____

6. Do you or the baby's father have 2 or more close relatives with cerebral palsy? Yes No

7. Do you or the baby's father have 2 or more close relatives with mental retardation? Yes No

8. Are there other known inherited disorders or diseased in the family (e.g. Polycystic Kidneys, Neurofibromatosis, Retinoblastoma, etc.)? If yes, please describe _____ Yes No

9. Have you taken any of the following drugs since your last menstrual period: Yes No
   (please circle) recreational drugs, seizure medications, anti-cancer drugs, anticoagulants (blood thinners), lithium, Accutane or alcohol (more than 2 drinks/glasses daily)? List any others: _____

10. Have you been exposed to x-rays or viral illness since your last menstrual period? Yes No

11. Do you have a family history of twins or triplets? Yes No

12. If you have any additional concerns not listed above, please describe: _____

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