



# Genetic Family History & Pregnancy Questionnaire

## Section 1. Patient Information.

Appointment Date \_\_\_\_\_

Name \_\_\_\_\_ DOB \_\_\_\_\_ Occupation \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Home Phone \_\_\_\_\_ Work Phone \_\_\_\_\_

Referring Physician \_\_\_\_\_ Phone Number \_\_\_\_\_

## Section 2. Father of the Pregnancy Information.

Name \_\_\_\_\_ DOB \_\_\_\_\_ Occupation \_\_\_\_\_

## Section 3. Are you or the father of the pregnancy from any of these ethnic backgrounds. Please check all that apply.

	Patient	Father of Pregnancy
Chinese, Asian, Indian, Taiwanese, Filipino, Korean or Southeast Asian .....	<input type="checkbox"/>	<input type="checkbox"/>
Italian, Greek, Middle Eastern or Spanish .....	<input type="checkbox"/>	<input type="checkbox"/>
Jewish, French, Canadian or Cajun .....	<input type="checkbox"/>	<input type="checkbox"/>
African American, African, Black, Puerto Rican, Caribbean or Central American .....	<input type="checkbox"/>	<input type="checkbox"/>
Hispanic or Mexican .....	<input type="checkbox"/>	<input type="checkbox"/>
Caucasian .....	<input type="checkbox"/>	<input type="checkbox"/>
Other (specify) _____		

## Section 4. Have you, the father of the pregnancy, or anyone in your families ever had the following conditions?

	Yes	NO		Yes	NO
Down Syndrome .....	<input type="checkbox"/>	<input type="checkbox"/>	Polycystic kidney disease .....	<input type="checkbox"/>	<input type="checkbox"/>
Other Chromosome Problem.....	<input type="checkbox"/>	<input type="checkbox"/>	Huntington disease .....	<input type="checkbox"/>	<input type="checkbox"/>
Mental Retardation or Autism .....	<input type="checkbox"/>	<input type="checkbox"/>	Heart defect at birth.....	<input type="checkbox"/>	<input type="checkbox"/>
Spina Bifida (open spine) .....	<input type="checkbox"/>	<input type="checkbox"/>	Cleft lip/cleft palate.....	<input type="checkbox"/>	<input type="checkbox"/>
Anencephaly (opening in head/brain).....	<input type="checkbox"/>	<input type="checkbox"/>	Blindness/deafness .....	<input type="checkbox"/>	<input type="checkbox"/>
Blood Disorder, (such as Hemophilia or sickle cell).....	<input type="checkbox"/>	<input type="checkbox"/>	Baby who died after birth or within first year.....	<input type="checkbox"/>	<input type="checkbox"/>
Muscular Dystrophy or neuromuscular disease .....	<input type="checkbox"/>	<input type="checkbox"/>	Stillborn or 2 or more pregnancy losses.....	<input type="checkbox"/>	<input type="checkbox"/>
Cystic Fibrosis .....	<input type="checkbox"/>	<input type="checkbox"/>	Any birth defect not listed above .....	<input type="checkbox"/>	<input type="checkbox"/>
Neurofibromatosis.....	<input type="checkbox"/>	<input type="checkbox"/>	Any other inherited (genetic) condition .....	<input type="checkbox"/>	<input type="checkbox"/>
Skeletal disorder, (like dwarfism).....	<input type="checkbox"/>	<input type="checkbox"/>	Any other serious medical condition or surgery .....	<input type="checkbox"/>	<input type="checkbox"/>
Are you, or the father of the pregnancy, adopted? .....				<input type="checkbox"/>	<input type="checkbox"/>
Are you and the father of the pregnancy related to each other—other than by marriage? .....				<input type="checkbox"/>	<input type="checkbox"/>
Is there a history of infertility for you or the father of the pregnancy? .....				<input type="checkbox"/>	<input type="checkbox"/>
Was there a donation of egg or sperm used in this pregnancy? .....				<input type="checkbox"/>	<input type="checkbox"/>
Have you had preimplantation genetic diagnosis (PGD) or intracytoplasmic sperm injection (ICSI)? .....				<input type="checkbox"/>	<input type="checkbox"/>

## Section 5. If you are currently pregnant, please complete the following information.

	Yes	NO		Yes	NO
Due date: _____			Rashes, infectious diseases or fevers .....	<input type="checkbox"/>	<input type="checkbox"/>
Medications .....	<input type="checkbox"/>	<input type="checkbox"/>	Spotting, bleeding or any other complication.....	<input type="checkbox"/>	<input type="checkbox"/>
Please list: _____			Diabetes, PKU or lupus .....	<input type="checkbox"/>	<input type="checkbox"/>
Recreational drugs .....	<input type="checkbox"/>	<input type="checkbox"/>	A multiple marker blood screening test.....	<input type="checkbox"/>	<input type="checkbox"/>
Alcoholic drinks .....	<input type="checkbox"/>	<input type="checkbox"/>	(AFP blood screen, triple marker screen, maternal serum screen, AFP3, AFP4, etc.) .....	<input type="checkbox"/>	<input type="checkbox"/>
Exposure to X-Rays .....	<input type="checkbox"/>	<input type="checkbox"/>	Date of blood test _____		
Cigarette smoking .....	<input type="checkbox"/>	<input type="checkbox"/>			

I answered these questions to the best of my knowledge

\_\_\_\_\_  
Patient signature

\_\_\_\_\_  
Date

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