Genetic Family History & Pregnancy Questionnaire

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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	☐	☐
Italian, Greek, Middle Eastern or Spanish	☐	☐
Jewish, French, Canadian or Cajun	☐	☐
African American, African, Black, Puerto Rican, Caribbean or Central American	☐	☐
Hispanic or Mexican	☐	☐
Caucasian	☐	☐

Other (specify) ______________________

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

	Yes	NO
Down Syndrome	☐	☐
Other Chromosome Problem	☐	☐
Mental Retardation or Autism	☐	☐
Spina Bifida (open spine)	☐	☐
Anencephaly (opening in head/brain)	☐	☐
Blood Disorder, (such as Hemophilia or sikle cell)	☐	☐
Muscular Dystrophy or neuromuscular disease	☐	☐
Cystic Fibrosis	☐	☐
Neurofibromatosis	☐	☐
Skeletal disorder, (like dwarfism)	☐	☐

	Yes	NO
Polycystic kidney disease	☐	☐
Huntington disease	☐	☐
Heart defect at birth	☐	☐
Cleft lip/cleft palate	☐	☐
Blindness/deafness	☐	☐
Baby who died after birth or within first year	☐	☐
Stillborn or 2 or more pregnancy losses	☐	☐
Any birth defect not listed above	☐	☐
Any other inherited (genetic) condition	☐	☐
Any other serious medical condition or surgery	☐	☐
Are you, or the father of the pregnancy, adopted?	☐	☐
Are you and the father of the pregnancy related to each other–other than by marriage?	☐	☐
Is there a history of infertility for you or the father of the pregnancy?	☐	☐
Was there a donation of egg or sperm used in this pregnancy?	☐	☐
Have you had preimplantation genetic diagnosis (PGD) or intracytoplasmic sperm injection (ICSI)?	☐	☐

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

Due date:____________

	Yes	NO
Medications	☐	☐
Please list:____________		
Recreational drugs	☐	☐
Alcoholic drinks	☐	☐
Exposure to X-Rays	☐	☐
Cigarette smoking	☐	☐

	Yes	NO
Rashes, infectious diseases or fevers	☐	☐
Spotting, bleeding or any other complication	☐	☐
Diabetes, PKU or lupus	☐	☐
A multiple marker blood screening test	☐	☐
(AFP blood screen, triple marker screen, maternal serum screen, AFP3, AFP4, etc.)	☐	☐

Date of blood test____________

I answered these questions to the best of my knowledge ____________ ________

Patient signature Date

FOR OFFICE USE ONLY

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