

Name: \_\_\_\_\_

MR#: \_\_\_\_\_

## Prenatal Genetic Screening Questionnaire

### Check if yes:

1. **Have you, the baby's father, or anyone in either of your families ever had any of the following disorders or pregnancy histories? If yes, please note your relationship to the affected person and give details.**

- (a) Any chromosomal abnormalities (such as Down syndrome)? \_\_\_\_\_
- (b) Any neural tube defect (spina bifida, anencephaly)? \_\_\_\_\_
- (c) Any blood disorder (such as hemophilia, sickle cell, thalassemia, clotting disorder)? \_\_\_\_\_
- (d) Any nerve or muscle disorder (such as neurofibromatosis, muscular dystrophy)? \_\_\_\_\_
- (e) Any bone or skeletal disorder (such as dwarfism)? \_\_\_\_\_
- (f) Cystic fibrosis (a lung disease)? \_\_\_\_\_
- (g) Polycystic kidney disease (requires dialysis/transplant)? \_\_\_\_\_
- (h) Heart defect (at birth)? \_\_\_\_\_
- (i) Cleft lip/palate? \_\_\_\_\_
- (j) Mental retardation? \_\_\_\_\_
- (k) Any genetic condition? \_\_\_\_\_
- (l) Any birth defect not listed above? \_\_\_\_\_
- (m) A serious medical problem that you are concerned about? \_\_\_\_\_
- (n) A child who died shortly after birth or during childhood? \_\_\_\_\_
- (o) A baby who needed surgery before one year of age? \_\_\_\_\_
- (p) Any childhood cancer or early malignancy? \_\_\_\_\_

2.  **Do you have insulin-dependent diabetes?**

3.  **Have you or the baby's father had a stillbirth or three or more pregnancy losses?**

4.  **Was this pregnancy achieved through in-vitro fertilization (IVF) or other assisted reproductive methods?** If yes, was there:  sperm donor  egg donor  ICSI  Other: \_\_\_\_\_

5. **Have you taken any of the following during your pregnancy?**

- |                                                             |                                                                                                    |
|-------------------------------------------------------------|----------------------------------------------------------------------------------------------------|
| <input type="checkbox"/> Alcohol (2 or more drinks per day) | <input type="checkbox"/> Anti-seizure medication (like Dilantin, Tegretol, Depakote, or Trileptal) |
| <input type="checkbox"/> Anti-cancer medications            | <input type="checkbox"/> Lithium, Depakote, or Tegretol                                            |
| <input type="checkbox"/> Accutane (anti-acne)               | <input type="checkbox"/> ACE inhibitors (blood pressure medications like Zestril, Capoten, etc.)   |
| <input type="checkbox"/> Anticoagulants (blood thinners)    | <input type="checkbox"/> Cholesterol-lowering medications (statins)                                |

6.  **Do you smoke cigarettes?**

7.  **Are you and the baby's father related by blood (such as cousins)?**

8. **What countries are your ancestors from (before coming to the USA)/what is your ethnic background?**

Yourself: \_\_\_\_\_ Father of the baby: \_\_\_\_\_

**Patient Signature:** \_\_\_\_\_

**Date:** \_\_\_\_\_

**Reviewed by:** \_\_\_\_\_

**Date:** \_\_\_\_\_

Your responses will be reviewed by a genetic counselor and you will be contacted **only if** it is determined that your pregnancy may have a higher chance for birth defects or inherited conditions.