

PFCPMC Prenatal Genetic Screening Questionnaire

(Please Print)

Patient Name: _____ Patient Date of Birth: _____

Patient Occupation: _____ Patient Countries of Ancestry: _____

Partner Name: _____ Partner Date of Birth: _____

Partner Occupation: _____ Partner Countries of Ancestry: _____

Family and Patient History

*Close relative indicates child, mother, father, sister, brother, aunt, uncle, or grandparent

1. Do you, the baby's father, or anyone in either of your families have or had any of the following disorders?

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

2. Are you and the baby's father related by blood: for example, cousins? No ___ Yes ___

3. Do you or the baby's father have any close relatives* with mental retardation? No ___ Yes ___

• Please indicate the cause, if known: _____

4. Other Medical Problems

- a. Do you, the baby's father, or a close relative* in either of your families have a genetic condition or chromosome abnormality not listed above? No ___ Yes ___
- b. Do you, the baby's father, or a close relative* in either of your families have a birth defect not listed above? No ___ Yes ___
- c. Do you, the baby's father, or a close relative* in either of your families have a serious medical problem that you are concerned about (such as diabetes)? No ___ Yes ___

5. Previous Pregnancy

- a. Have you or the baby's father had a baby who died shortly after birth or in the first year?..... No ___ Yes ___
- b. Have you or the baby's father had a stillborn child or two or more first trimester spontaneous pregnancy losses? No ___ Yes ___
- c. Have you or your partner ever been treated by a physician for infertility? No ___ Yes ___
- d. Is this pregnancy a result of reproductive technology (e.g. IVF, ICSI)? No ___ Yes ___

• If Yes, please specify: _____

6. Have you had an ultrasound in this pregnancy? No ___ Yes ___

7. Excluding vitamins and iron, have you taken medications, street drugs, or alcohol since being pregnant or since your last menstrual period? No ___ Yes ___

8. Do you have diabetes? No ___ Yes ___

9. Have you had the Expanded AFP screening test in this pregnancy? No ___ Yes ___

10. If Yes to any questions above, please explain: _____

Completed by: _____ Date: _____

Reviewed by: _____ Date: _____