

PFCCPMC Prenatal Genetic Screening Questionnaire

(Please Print)

Patient Name: _____

Partner Name: _____

Date of Birth: _____

Date of Birth: _____

Occupation: _____

Occupation: _____

Countries of Ancestry: _____

Countries of Ancestry: _____

Family and Patient History

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

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

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?.....

Please indicate the cause, if known: _____

4. 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?.....

b. Do you, the baby's father, or a close relative* in either of your families have a birth defect not listed above?.....

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)?.....

5. a. Have you or the baby's father had a baby who died shortly after birth or in the first year?.....

b. Have you or the baby's father had a stillborn child or two or more first trimester spontaneous pregnancy losses?.....

c. Have you or your partner ever been treated by a physician for infertility?.....

d. Is this pregnancy a result of reproductive technology (e.g. IVF, ICSI)?.....

If yes, please specify: _____

6. Have you had an ultrasound in this pregnancy?.....

7. Excluding vitamins and iron, have you taken medications, street drugs, or alcohol since being pregnant or since your last menstrual period?.....

8. Do you have diabetes?.....

9. Have you had the Expanded AFP screening test in this pregnancy?.....

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

Completed by: _____

Date: _____

Reviewed by: _____

Date: _____

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