



GENETIC FAMILY HISTORY & PREGNANCY QUESTIONNAIRE

Date of Appointment _____

Section 1. Patient Information

Name _____ Date of Birth _____ Occupation _____
 Address _____ City _____ State _____ ZIP _____
 Home phone _____ Work phone _____ Cell phone _____
 Referring Physician's Name _____ Referring Physician's Phone Number _____

Section 2. Partner Information (If patient is pregnant, then "partner" is the father of the pregnancy)

Name _____ Date of Birth _____ Occupation _____

The following questions will help your genetic counselor complete a genetic risk assessment and determine if certain tests are appropriate. If you are unsure about your family history, please speak with family members.

Section 3. Are you or your partner from any of these ethnic backgrounds?

Please circle and check all that apply

	Patient	Partner
Chinese, Taiwanese, Asian Indian, Pakistani, Filipino or Southeast Asian	<input type="checkbox"/>	<input type="checkbox"/>
Italian, Greek, Middle Eastern, Spanish or Portuguese	<input type="checkbox"/>	<input type="checkbox"/>
Jewish, French Canadian or Cajun	<input type="checkbox"/>	<input type="checkbox"/>
African American, African descent, 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) _____	<input type="checkbox"/>	<input type="checkbox"/>

Section 4. Have you, your partner 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 your partner adopted? Yes No

Are you and your partner related to each other - other than by marriage? Yes No

Is there a history of infertility in either you and/or your partner? Yes No

Please specify the cause of infertility, if known. _____

Have you and/or your partner had carrier testing for cystic fibrosis? Yes No

Have you and/or your partner had carrier testing for any other genetic disorder? Yes No

Have you and/or your partner had blood chromosome testing? Yes No

Section 5. Please complete the following patient information:

	Yes	No		Yes	No
current medications	<input type="checkbox"/>	<input type="checkbox"/>	Do you have diabetes, PKU or lupus?	<input type="checkbox"/>	<input type="checkbox"/>
Please list:			Are you considering or have you used:		
recreational drugs	<input type="checkbox"/>	<input type="checkbox"/>	egg donor or donor sperm	<input type="checkbox"/>	<input type="checkbox"/>
alcoholic drinks	<input type="checkbox"/>	<input type="checkbox"/>	preimplantation genetic diagnosis (PGD) ..	<input type="checkbox"/>	<input type="checkbox"/>
cigarette smoking	<input type="checkbox"/>	<input type="checkbox"/>	intracytoplasmic sperm injection (ICSI) ...	<input type="checkbox"/>	<input type="checkbox"/>

Section 6. If you are currently pregnant, have you had any of the following: Due Date: _____

	Yes	No		Yes	No
rashes, infections, fevers	<input type="checkbox"/>	<input type="checkbox"/>	Have you had maternal serum screening?	<input type="checkbox"/>	<input type="checkbox"/>
spotting, bleeding or any other complications ...	<input type="checkbox"/>	<input type="checkbox"/>	(such as AFP blood screen, AFP3, AFP4,		
exposure to X-rays	<input type="checkbox"/>	<input type="checkbox"/>	triple marker screen, first trimester screen)		

I have answered these questions to the best of my knowledge.

Patient's signature

Date

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