



Genetic Family History & Pregnancy Questionnaire

Part 1. Patient Information

Date of Appointment _____

Name, Address, Home Phone, Referring Physician's Name, Date of Birth, City, Work Phone, Occupation, State, Zip, Cell Phone, Physician's Phone Number

Part 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 us 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.

Part 3. Have you, your partner or anyone in your families ever had the following conditions:

Table with columns: Yes, No, Yes, No. Rows include Down syndrome, 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, and questions about adoption, relationship, and infertility.

Part 4. Are you or your partner from any of these ethnic backgrounds?

Please circle and check all that apply

Table with columns: Patient, Partner. Rows include Chinese, Taiwanese, Asian Indian, Pakistani, Filipino or Southeast Asian, Italian, Greek, Middle Eastern, Spanish or Portuguese, Jewish, French Canadian or Cajun, African American, African descent, Black, Puerto Rican, Caribbean or Central American, Hispanic or Mexican, Caucasian, and Other (specify).

Part 5. Please complete the following patient information:

Table with columns: Yes, No, Yes, No. Rows include medications (current or during pregnancy), recreational drugs, alcoholic drinks, cigarette smoking, Do you have diabetes, PKU or lupus?, and Are you considering or have you used: egg donor or donor sperm, preimplantation genetic diagnosis (PGD), intracytoplasmic sperm injection (ICSI).

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

Table with columns: Yes, No, Yes, No. Rows include rashes, infections, fevers, spotting, bleeding or any other complications, exposure to X-rays, and Have you had maternal serum screening (such as AFP blood screen, AFP3, AFP4, triple marker screen, first trimester screen)?

I have answered these questions to the best of my knowledge: _____ Date: _____

