Patient's Name________________________________ Date of Birth ______/______/_______

Genetic History Questionnaire for Prenatal Patients

The answers to these questions will help in the care of your pregnancy.
Please answer these questions as well as you can. All answers will remain private.
If you need help answering the questions, please ask.

1. When your baby is born, will you be 35 years of age or older? ☐ No ☐ Yes

Where your ancestors came from may sometimes give us important information about the health of your baby.

2. Is your family…….

From Southeast Asia, Taiwan, China or the Philippines? ☐ No ☐ Yes ☐ Not Sure

From Italy, Greece or the Middle East? ☐ No ☐ Yes ☐ Not Sure

African American (Black)? ☐ No ☐ Yes ☐ Not Sure

Hispanic/Puerto Rican? ☐ No ☐ Yes ☐ Not Sure

3. Is your family, or your baby's father's family European (Ashkenazi) Jewish?
☐ No ☐ Yes ☐ Not Sure

The next nine questions will be about you, you baby's father and both of your families. When we say "blood relative" we mean your child(or unborn baby), mother, father, sister, brother, grandparent, aunt, uncle, niece, nephew or cousin

4. Were you, or your baby's father or any blood relative born with an opening in the back or spine, also called Spina Bifida ☐ No ☐ Yes ☐ Not Sure

5. Was there ever a baby (or unborn baby) in you family or your baby's father's family who had an opening in the head, also called Anencephaly? ☐ No ☐ Yes ☐ Not Sure

6. Is any blood relative in your family or your baby's father's family mentally retarded?
☐ No ☐ Yes ☐ Not Sure

7. Have you, or your baby's father, or any blood relative had an unborn baby or a child who had Down syndrome (some call it trisomy 21)? ☐ No ☐ Yes ☐ Not Sure

8. Do you, or your baby's father , or any blood relative have any other chromosome problems?
☐ No ☐ Yes ☐ Not Sure

Ask you health care provider about multiple marker screening for Down syndrome, spina bifida, and trisomy 18, even if there is NO history of these in your or your baby's father's family

(additional questions on reverse side)

9. Do you, or does your baby's father, or any blood relative have:

a. Cystic Fibrosis (CF)? ☐ No ☐ Yes ☐ Not Sure

b. Fragile X Syndrome? ☐ No ☐ Yes ☐ Not Sure

c. Muscular Dystrophy? ☐ No ☐ Yes ☐ Not Sure

d. Hemophilia or other bleeding disorder? ☐ No ☐ Yes ☐ Not Sure

e. Huntington disease? ☐ No ☐ Yes ☐ Not Sure

10. Were you, or your baby's father, or any blood relative born with:

a. A heart defect? ☐ No ☐ Yes ☐ Not Sure

b. A cleft lip and/or cleft palate? ☐ No ☐ Yes ☐ Not Sure

c. Any other birth defect? ☐ No ☐ Yes ☐ Not Sure

11. Have you ever had:

a. Two or more miscarriages? ☐ No ☐ Yes

b. A stillborn baby **and** one or more miscarriages(s) ☐ No ☐ Yes

12. Do you, or does your baby's father, or any blood relative have any other disease or health problem that is inherited (passed on in the family)? ☐ No ☐ Yes ☐ Not Sure

The next three questions will be about medical conditions that you (the patient) may have.

13. Do you have diabetes? ☐ No ☐ Yes ☐ Not Sure

14. Do you have, or have you ever been treated for PKU (phenylketonuria) or hyperphenylalaninema (hyperphe)? ☐ No ☐ Yes ☐ Not Sure

15. During this pregnancy, have you taken:

a. Seizure medications? (Dilantin, Valproic acid, Depakene, Tegretol, Atretol, Mysoline, Tridione)
☐ No ☐ Yes

b. Lithium (Eskalith, Lithobid, Lithonate) for bipolar disorder or depression?
☐ No ☐ Yes

c. Pills (Accutane, Isotretinoin) for acne? ☐ No ☐ Yes

d. Chemotherapy/immunosuppressive medication (methotrexate, amniopterin, rheumatrex)
☐ No ☐ Yes

Providers signature_________________________________ **Date**_____/_______/_______