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“Providing high quality healthcare for all stages in a woman’s life”

MEDICAL GENETIC QUESTIONNAIRE

Patient Name (Print): _____

1. How many times have you been pregnant including this one? _____
2. How many liveborns have you had? _____
3. Are all your liveborn children still living? No Yes
4. Have you had any of the following?
 - a. Miscarriage? No Yes
 - b. Stillbirth? No Yes
 - c. Children born with any birth defects (e.g., spinal bifida, heart defect, limb defect)? No Yes
 - d. Children born with mental retardation? No Yes
 - e. Children born with chromosomal abnormalities (e.g., Down's syndrome, Turner's syndrome) No Yes
5. Has anyone in your family had any of the following?
 - a. Birth defects? No Yes
 - b. Mental retardation? No Yes
 - c. Chromosomal abnormalities? No Yes
6. Are there any diseases that run in your family? No Yes
7. How old is the baby's father? _____
8. Does anyone in his family have any of the following?
 - a. Birth defects? No Yes
 - b. Mental retardation? No Yes
 - c. Chromosomal abnormalities? No Yes
9. Are there any diseases that run in the father of the baby's family? No Yes
10. Are you or the baby's father of:
 - a. Eastern European Jewish (Ashkenazi) descent? No Yes
 - b. Italian, Greek, or Southeast Asian descent? No Yes
 - c. African descent (e.g., African American, Ethiopian, Haitian, Nigerian, West Indian, other)? No Yes



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MEDICAL GENETIC QUESTIONNAIRE (Continued)

Patient Name (Print): _____

- 11. Have you or the baby's father been tested for:
 - a. Tay Saches disease? No Yes
 - b. Thalassemia? No Yes
 - c. Sickle Cell anemia? No Yes
- 12. Will you be 35 years old or older when this baby is born? No Yes
- 13. Do you?
 - a. smoke? No Yes
 - b. drink? No Yes
 - c. use recreational or street drugs? No Yes
- 14. Do you have any chronic medical problems? No Yes
- 15. During this pregnancy have you had?
 - a. any type of illness? No Yes
 - b. fever? No Yes
- 16. Do you take any medication on a regular basis? No Yes
 - a. prescription? _____
 - b. non -prescription? _____
- 17. During this pregnancy have you taken any prescription or non-prescription medications? No Yes
 - If yes what? _____
 - _____
- 18. Do you take vitamins? No Yes
- 19. Do you follow any special diets (e.g., vegetarian)? No Yes
- 20. Have you had any X-rays done during this pregnancy? No Yes
- 21. Have you been exposed to any possible chemicals at home or at work? No Yes
- 22. Have you had any surgery done during this pregnancy? No Yes

Signature: _____

Date _____