



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
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
Other (specify) _____

Section 4. Have you, your partner or anyone in your families ever had the following conditions:

Down syndrome
other chromosome problem
mental retardation or autism
spina bifida (open spine)
anencephaly (opening in head/brain)
blood disorder, such as hemophilia or sickle cell
muscular dystrophy or neuromuscular disease
cystic fibrosis
neurofibromatosis
skeletal disorder, like dwarfism
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

Are you or your partner adopted?
Are you and your partner related to each other - other than by marriage?
Is there a history of infertility in either you and/or your partner?
Please specify the cause of infertility, if known.
Have you and/or your partner had carrier testing for cystic fibrosis?
Have you and/or your partner had carrier testing for any other genetic disorder?
Have you and/or your partner had blood chromosome testing?

Section 5. Please complete the following patient information:

current medications
Please list:
recreational drugs
alcoholic drinks
cigarette smoking
Do you have diabetes, PKU or lupus?
Are you considering or have you used:
egg donor or donor sperm
preimplantation genetic diagnosis (PGD)
intracytoplasmic sperm injection (ICSI)

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

rashes, infections, fevers
spotting, bleeding or any other complications
exposure to X-rays
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.

Patient's signature _____ Date _____

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