Prenatal Screening Form

Please answer the questions below to the best of your ability. You may have to speak to family members to get the most accurate information. When asked for information about your family members and those of your baby's father, we are interested in learning about you, your baby's father, any other children that either of you might have and both of your parents, brothers, sisters, grandparents, aunts, uncles, cousins, nieces, and nephews.

Initials

_____ 1.How old will you be when you deliver this baby? _____ How old is your baby's father? _____

_____ 2. Is there any history of birth defects, such as cleft lip or palate, spina bifida, a heart defect, a limb abnormality (such as club foot), a brain or kidney abnormality, a defect in the abdominal wall, or any other birth defect in you, your family, or your baby's father or his family?

YES NO

_____ 3. Has anyone in your family or your baby's father's family had surgery as an infant, died early in childhood, or suffered from an unusual illness or chronic condition?

YES NO

_____ 4. Is there any history of mental retardation, autism, developmental delays, or Fragile X syndrome in anyone in your family or your baby's father's family?

YES NO

_____ 5. Is there any history of any genetic disease, including Down's Syndrome, Cystic Fibrosis, Muscular Dystrophy, Hemophilia, Huntington's Chorea, Phenylketonuria, a congenital hearing loss, or any other chromosomal abnormality or genetic disease in your family or your baby's father's family?

YES NO

_____ 6. Have you ever been screened to see if you are a carrier for Cystic Fibrosis?

YES NO

_____ 7. Does any birth defect or distinctive mark run in your family or your baby's father's family? Examples might include missing digits, light brown birthmarks, club feet, & hair patches at the base of the spine?

YES NO

_____ 8. Have you (or your baby's father in a prior relationship) had 2 or more miscarriages or any stillbirths?

YES NO

_____ 9. Are you or your baby's father Jewish, French Canadian, or Cajun descent?

YES NO

If YES, have you ever had carrier screening for any of the Ashkenazi Jewish diseases (Tay Sachs, Canavans etc)?

YES NO

_____ 10. Are you or your baby's father African American, Hispanic, or African descent?

YES NO

_____ 11. Are you or your baby's father of Greek, Italian, African American, Mediterranean, or Asian descent?

YES NO

If YES, is there any family history of thalassemia (Cooley's anemia)?

YES NO

_____ 12. Are you or your baby's father blood relatives or are there any married couples in your families that might be blood relatives?

YES NO

_____ 13. Have you, your baby's father, or any family members had hepatitis or liver disease?

YES NO

_____ 14. Do you have any ongoing medical problems that require a doctor's care, such as thyroid problems, high blood pressure, diabetes, heart disease, or a seizure disorder?

YES NO

_____ 15. Have you ever experienced a depression (low mood, the "blues", or postpartum depression) lasting longer than two weeks? Did you seek professional treatment or use any medication?

YES NO

_____ 16. Have you taken any drugs or medicines (over-the-counter, prescription, or recreational) since your last period?

YES NO

If YES, what have you taken:

_____

KENDALL
ONE SEVENTEEN PROFESSIONAL ARTS CENTER
8200 SW 117TH AVE, SUITE 304, MIAMI, FL 33183
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DORAL
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WEST KENDALL OBGYN

Prenatal Screening Form

Initials

_____ 17. Do you smoke cigarettes? If YES, how many per day? _____

YES NO

_____ 18. Have you had any major surgery?

YES NO

If YES, please list all surgeries:

_____

_____

_____

_____ 19. Are there any medical problems that have not been mentioned in your family or your baby's father's family that worry or concern you for any reason?

YES NO

If YES, please explain:

_____

_____

_____

_____ 20. Have you been exposed to any viral illness or had any unusual rash since your last period?

YES NO

_____ 21. Do you have any objections to receiving blood or blood products in an emergency situation?

YES NO

_____ 22. Do you own a cat? If so, who changes the litter?

YES NO

_____ 23. Have you ever had the chickenpox or been immunized against varicella (chickenpox)?

YES NO

_____ 24. Have you or your partner ever had oral or genital herpes?

YES NO

_____ 25. Have you ever had a blood transfusion or received any blood products?

YES NO

_____ 26. Do you accept testing for the HIV virus?

YES NO

Please use the space below to make any other comments that you feel might be important for us to know about you or that might help us to take care of you during your pregnancy:

_____

_____

_____

_____

_____

_____

I, _____ , have discussed the above questions that are answered "yes" with my doctor and understand the availability and importance of genetic counseling. I wish to obtain genetic counseling.

_____ _____ _____

Signature Date of Birth Date

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