Genetic Screening Questionnaire

Patient Name: _____ Date of Birth: _____

Doctor/Clinic: _____ Today's date: _____

The following questionnaire will help identify genetic risk factors that may affect you or your children. Your answers may indicate that certain tests would be appropriate. Please answer all questions as completely as possible. All information will be kept confidential.

1. If you are pregnant, will you be 35 or older at your due date? ☐ Yes ☐ No Your due date is _____

2. Are you, the father of the pregnancy, or your ancestors from any of these ethnic backgrounds:
   Asian (except Japanese or Korean). Southeast Asia, Pacific Islander, Mediterranean, Southern European, Central American, Caribbean, Middle Eastern, or African American or Black?
   ☐ Yes ☐ No ☐ Don't Know

   Have you or the father of the pregnancy been tested to see if you are a carrier of thalassemia, sickle cell anemia, or another hemoglobin abnormality?
   ☐ Yes ☐ No ☐ Don't Know
   If yes, who was tested or what were the results? _____

3. Are you or the father of the pregnancy Jewish, French Canadian, or Cajun background?
   ☐ Yes ☐ No ☐ Don't Know

4. Have you or the father of the pregnancy had carrier testing for any other genetic diseases?
   ☐ Yes ☐ No ☐ Don't Know

5. Were you, the father of the pregnancy, or anyone in your families born with an opening in the spine or head (such as a neural tube defect, spina bifida, or anencephaly)?
   ☐ Yes ☐ No ☐ Don't Know

6. Were you, the father of pregnancy, or anyone in your families born with a heart defect, or cleft palate?
   ☐ Yes ☐ No ☐ Don't Know

7. Have you, the father of the pregnancy, or anyone in your families had a pregnancy or child diagnosed with down syndrome or any other chromosome abnormality?
   ☐ Yes ☐ No ☐ Don't Know

8. Do you, the father of the pregnancy, or anyone in your families have hemophilia or another bleeding disorder?
   ☐ Yes ☐ No ☐ Don't Know

9. Have you, the father of the pregnancy, or anyone in your families been diagnosed with spinal and muscular atrophy, muscular dystrophy, or another neuromuscular disease?
   ☐ Yes ☐ No ☐ Don't Know

10. Do you, the father of the pregnancy, or anyone in your family have cystic fibrosis?
    ☐ Yes ☐ No ☐ Don't Know
    Is yes, how is this person related to you or the father of the pregnancy? _____

11. Do you, the father of the pregnancy, or anyone in your families have autism, mental retardation, or fragile X syndrome?
    ☐ Yes ☐ No ☐ Don't Know
    If yes, please write the diagnosis or describe the disorder. _____
    How is this person related to you or the father of the pregnancy? _____

12. Did you, the father of the pregnancy, or anyone in your families have any other birth defect or serious medical condition in infancy or childhood?
    ☐ Yes ☐ No ☐ Don't Know
    If yes, please describe. _____
    How is the person related to you or the father of the pregnancy? _____

13. Do you have diabetes, a seizure disorder (epilepsy), lupus, PKU (phenylketonuria), or another chronic medical condition?
    ☐ Yes ☐ No ☐ Don't Know
    If yes, please write the diagnosis. _____

14. Do you, the father of the pregnancy, or anyone in your families have an inherited disorder or birth defect not previously mentioned in this questionnaire?
    ☐ Yes ☐ No ☐ Don't Know
    If yes, please write the diagnosis or describe the defect. _____
    How is the person related to you or the father of the pregnancy? _____

15. Are you related to the father of the pregnancy (other than by marriage)?
    ☐ Yes ☐ No
    If yes, how? _____

16. Do you have a history of premature ovarian insufficiency (or loss of normal ovarian function prior to age 40)?
    ☐ Yes ☐ No

17. Have you or the father of the pregnancy had a stillborn child or two or more pregnancy losses in this or any other relationship?
    ☐ Yes ☐ No

18. Was this pregnancy conceived through IVF?
    ☐ Yes ☐ No
    If yes, was ICSI OR PGD (preimplantation genetic diagnosis) used?
    ☐ Yes ☐ No

19. Have you taken any recreational drugs, had any alcoholic drinks, or taken any medications (other than prenatal vitamins since your last menstrual period?
    ☐ Yes ☐ No ☐ Don't remember

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

Patient Signature