Frederick OB/GYN Division

PRENATAL DIAGNOSIS SCREENING QUESTIONNAIRE

YOUR NAME: ________________________________ DATE:______________________________

1. Will you be 35 years of age or older when you have children? YES____NO_____
2. Have you, your partner, or anyone in either of your families ever had any of the following?
   - A. Down's Syndrome (mongolism) YES____NO_____
   - B. Spina bifida or meningomyelocele (open spine) YES____NO_____
   - C. Hemophilia YES____NO_____
   - D. Muscular dystrophy YES____NO_____
   - E. Cystic Fibrosis YES____NO_____
3. Have you or your partner had a child born (dead or alive) with a birth defect not listed in # 2.? YES____NO_____
4. Do you or your partner have any close relatives in either of your families with any genetic (inherited) or chromosomal disease or any disorder not listed above? YES____NO_____
5. Do you or your partner have any close relatives who have a mental illness? YES____NO_____
6. Have you, your partner or close Family members had three or more spontaneous pregnancy losses? YES____NO_____
7. Do you or your partner have any close relatives descended from Jewish People? who live in Eastern Europe (Ashkanazic Jews)? YES____NO_____
   - If yes, have either you or your partner or close relative ever been screened for Tay-Sachs disease? YES____ NO_____
8. Are you or your partner African- American? YES____ NO_____
   - * If yes, have either of you or your partner or close relative ever been screened for sickle cell trait and found to be positive? YES____NO_____
9. Do you or your partner have any close relatives descended from
   - Mediterranean countries? YES____NO_____
   - Asia? YES____NO_____
   - Southeast Asia? YES____NO_____
   - Middle Eastern countries? YES____NO_____
   - West Indian countries? YES____NO_____
10. Have you or your partner ever had a genital herpes infection? YES____NO_____
11. Have you ever had chickenpox? YES____NO_____
12. Have you or any of your family members had any bleeding problems or blood clots? YES____NO____
13. Have you or any of your family members been diagnosed with a learning disability, attention deficit disorder (ADD) or attention deficit/hyperactivity Disorder (ADHD)? YES____NO_____
14. Have you been exposed to any toxic substance or x-rays since your last menstrual period? YES____NO_____
15. Did your mother have any complications or medical conditions with her pregnancies? YES____NO_____
16 Has anyone in your or your partner's family had a stillborn or fetal death after 20 weeks? YES____NO_____
17. Do you currently take any prescription or " Over –the-Counter" medications? YES____NO_____

**If yes, please list the drugs and the dosage schedule

CWC use only: **Reviewed by/date:**____