Richard Bardowell, M.D., FACOG

PRENATAL SCREENING

NAME: ______________________ DATE ______________

Question	Please check YES	NO
1. Will you be 35 years or older when the baby is due ?		
2. Have you, the baby's father, or anyone in either of your families ever had any of the following disorders ? Down's Syndrome (mongolism) Other chromosomal abnormality Neural tube defect (spina bifida, anencephaly, etc.) Hemophilia Muscular Dystrophy Cystic Fibrosis		
3. Do you or the baby's father have a birth defect ? If yes, who has the defect and what is it ? ____________		
4. In any previous marriages, have you or the baby's father had a child, born dead or alive with a birth defect not listed in Question 2 above. If yes, what is it ? __________		
5. Do you or the baby's father have any close relatives with mental retardation ?		
6. Have you or the baby's father had a stillborn child or three or more first trimester pregnancy losses ?		
7. If you, or the baby's father are of Jewish ancestry, have either of you been screened for Tay-Sachs disease ? If yes, indicate who and the results ____________		
8. If you or the baby's father are black, have either of you been screened for sickle cell trait ? If yes, indicate who and the results ____________		
9. If you or the baby's father are of Italian, Greek, or Mediterranean background, have either of you been tested for beta-thalassemia ?		
10. Excluding iron and vitamins, have you taken any medications or recreational drugs since being pregnant or since your last menstrual period ? (Include over-the-counter drugs) If yes, give name of medication and time taken during pregnancy: ____________________		

Patient's signature ______________________ Date ______________