

## PRECONCEPTION GENETIC SCREENING QUESTIONNAIRE

**Patient Name:** \_\_\_\_\_ **DOB:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**This questionnaire will provide us with information about your genetic background with the goal of helping you plan for a healthy baby.**

**Frequently, a specific genetic disorder will run in a given family. Also, certain disorders are found more often in people of a particular ethnic background. If you are in a high risk group based on family history or ethnic background, there may be laboratory tests which can determine whether you or your children are carriers of genetic disorders. It is better to do these tests before you are pregnant or very early in the pregnancy.**

**Your participation in answering this questionnaire is voluntary. All information obtained will remain confidential.**

**Answer as well as you can. If you don't understand words, or are unsure if someone in your family had the problem, check "Not Sure" and ask your nurse or doctor.**

*Please circle:*

Are you 35 years of age or older?	Yes	No	Not sure
Is your partner 50 years of age or older?	Yes	No	Not sure

Do you, your partner or anyone in either of your families have any of the following disorders?:

Down Syndrome	Yes	No	Not sure
Other chromosome abnormalities (translocations, trisomies, deletions)	Yes	No	Not sure
Neural tube defects: Spina bifida (open spine), anencephaly (open skull)	Yes	No	Not sure
Huntington's disease/chorea	Yes	No	Not sure
Hemophilia / bleeding disorders	Yes	No	Not sure
Muscular dystrophy	Yes	No	Not sure
Cystic fibrosis	Yes	No	Not sure

If yes, indicate the relationship of the affected person to you and your partner: \_\_\_\_\_

Were you or your partner born with a congenital birth defect? Yes      No      Not sure

If yes, who is affected and what type of birth defect is present? \_\_\_\_\_

Have you or your partner had any children, born alive or dead, with any birth defect not listed above? Yes      No      Not sure

If yes, what was the defect and who was affected? \_\_\_\_\_

Do you or your partner have any relatives with mental retardation? Yes      No      Not sure

If yes, indicate the relationship of the affected person to you and your partner: \_\_\_\_\_

Indicate the cause, if known: \_\_\_\_\_

Do you, your partner, or anyone in your families have a birth defect, familial disorder, or a chromosome abnormality not listed above? Yes      No      Not sure

If yes, indicate the condition and the relationship of the affected person to you and your partner: \_\_\_\_\_

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Have you or your partner had 2 or more first trimester pregnancy losses or a stillborn child? Yes      No      Not sure

Have you or your partner had a chromosome analysis performed? Yes      No      Not sure

If yes, please indicate who, where it was performed, and the results : \_\_\_\_\_

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Are either you or your partner of Jewish ancestry? Yes      No      Not sure

If yes, have either of you been screened for Tay Sachs disease? (Please indicate who was tested and the results) \_\_\_\_\_

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Are either you or your partner of African American ancestry? Yes      No      Not sure

If yes, have either of you been screened for sickle cell trait? (Please indicate who was tested and the results) \_\_\_\_\_

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Are you or your partner of Italian, Greek, Mediterranean or Asian ancestry? Yes      No      Not sure

If yes, have either of you been screened for thalassemia? (Please indicate who was tested and the results: \_\_\_\_\_

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Have you been taking vitamins or folic acid during the last 6 months? Yes      No      Not sure

If yes, what vitamins? \_\_\_\_\_ How long? \_\_\_\_\_

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Do you have any of the following disorders?

Insulin dependent diabetes	Yes	No	Not sure
Autoimmune disorders such as lupus or rheumatoid arthritis	Yes	No	Not sure
Seizures or convulsions	Yes	No	Not sure

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Are you taking or do you use any of the following?

Lithium	Yes	No	Not sure
Valium	Yes	No	Not sure
Accutane (a drug for acne)	Yes	No	Not sure
Anticoagulants	Yes	No	Not sure
Anticonvulsants (drugs for seizure such as Dilantin, Phenobarbital)	Yes	No	Not sure
Iodides to treat Hyperthyroidism	Yes	No	Not sure
Anticancer drugs	Yes	No	Not sure
Birth control pills during pregnancy	Yes	No	Not sure
Alcohol	Yes	No	Not sure
Other drugs, please list:	Yes	No	Not sure

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Do you own a cat? Yes      No

Have you ever had the chicken pox? Yes      No      Not sure

Do you eat raw meat or fish? Yes      No

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Are there any health problems in you or your family that concern you? Yes      No      Not sure

If so, please explain: \_\_\_\_\_

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