Prenatal Risk Assessment

Patient Name: _____ **Date**: _____

1. Were you immunized against Rubella (German measles) as a child? Y/N
2. Have you had Chicken Pox or the Chicken Pox Vaccine? Y/N
3. What type of work do you do? _____
4. Will you be 35 years of age or older when your baby is born? Y/N
5. Do you or your baby's father have a birth defect or have you had a baby or a previous pregnancy with a birth defect? Y/N
6. Please check if any have occurred in your family/baby's father's family:

() Bleeding disorders (e.g. Hemophilia) () Congenital Kidney/Liver disease
() History of stillbirth () Enzyme Deficiency (e.g. PKU)
() Cystic Fibrosis () Huntington's disease
() Death of previous child () Neurofibromatosis
() Muscular Dystrophy () Multiple miscarriages
() Heart defect () Down's syndrome
() Spina Bifida or Anencephaly () Other Chromosome Abnormality
() Severe Anemia () Hydrocephaly
() Other_____

7. Do you or baby's father have any close relatives with Mental Retardation? Y/N
8. Are you and the baby's father related in any way (e.g. cousins)? Y/N
9. Are you or the baby's father of the following ancestry:

	Me	Baby's father
Ashkenazi (Eastern European) Jewish	()	()
French Canadian	()	()
Black, African American, Hispanic	()	()
Mediterranean, Italian, Greek	()	()

Office use only/ Test ordered:

Rubella/Varicella titers
Cystic Fibrosis /Fragile X
Spinal Muscular Atrophy (SMA)
Hemoglobinopathy (HGB)
Expanded Ashkenazi Panel
Other _____

10. Have you or your baby's father ever been tested for:

Sickle cell Trait Y/N Result: _____
B- Thalassemia Y/N Result: _____
Cystic Fibrosis Y/N Result: _____
Ashkenazi Profile Y/N Date: _____ Result: _____

10. Do you have any chronic medical conditions such as thyroid diseases, diabetes, PKU? Y/N
11. Have you taken any medications since your last menstrual period? Y/N If so what? _____
12. Do you have any Pets at home? Y/N If so what type? _____
13. Have you had any of the following since your last menstrual period:

Exposure to x-rays Y/N
Exposure to contagious illnesses Y/N
Alcohol consumption Y/N
Cigarettes Y/N
Exposure to any recreational drugs Y/N

Date: _____
Reviewed By: _____