Reset Form

WOMEN'S HEALTH PARTNERS, LLC

Diplomates of the American Board of Obstetrics & Gynecology

www.myobgynoffice.com

Print Form

PRENATAL GENETIC QUESTIONNAIRE

Name: _____

	Yes	No	
1) Will you be age 35 or older when your baby is due?	☐	☐	
2) Have you or your baby's father, or anyone in either of your family had:	Yes	No	
a) Down Syndrome (mongolism)?	☐	☐	
b) Spina Bifida or Anencephaly (open spine/ open brain)?	☐	☐	
c) Cystic Fibrosis?	☐	☐	
d) Bleeding disorder?	☐	☐	
d) Muscle disorder?	☐	☐	
e) Other birth defects?	☐	☐	
If yes, list type & exact relationship of affected individual(s):	☐	☐	
	Yes	No	
3) Do you or your baby's father have any relatives who are intellectually disabled?	☐	☐	
If yes, list cause (if known) and exact relationship of affected individual (s):			
	Yes	No	
4) Do you or your baby's father have a genetic disease or chromosomal disorder not listed above?	☐	☐	
If yes, list cause (if known) and exact relationship of affected individual (s):			
	Yes	No	
5) Do you or your baby's father have any blood relatives with any genetic (inherited) disorders?	☐	☐	
If yes, list cause (if known) and exact relationship of affected individual (s):			
	Yes	No	
6) Have you, or anyone your baby's father impregnated, had two or more spontaneous pregnancy losses?	☐	☐	
	Yes	No	
7) Are you and your baby's father blood relatives?	☐	☐	
If yes, what is the exact relationship?			
	Yes	No	
8) Are you and your baby's father of Jewish ancestry?	☐	☐	
If yes, have either of you been screened for Tay-Sachs, Canavan or cystic fibrosis?	☐	☐	
If yes, indicate who was screened and results:			
	Yes	No	
9) Are you and your baby's father of black ancestry?	☐	☐	
If yes, have either of you been screened for Sickle Cell disease?	☐	☐	
If yes, indicate who was screend and results:			
10) What is your ethnic background? (Where was your family born before coming to the United States?			
11) What is the ethnic background of your baby's father? (Where was his family born before coming to the United States)?			
	Yes	No	
12) Are you or your baby's father exposed to any chemical on a daily basis?	☐	☐	
if yes, what chemicals and under what circumstances			

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13) Have you taken any medications during this pregnancy? Yes ☐ No ☐

If so, list medications, dosages, dates and reason

	Medication	Dosage	Frequency	Reason
1.				
2.				
3.				
4.				

14) Were you using birth control when you became pregnant? Yes ☐ No ☐ _____

If yes, what type? _____

15) Have you or the baby's father had any x-rays within three months prior to the start of this pregnancy? if yes, list part of the body and date and if a shield was used. Yes ☐ No ☐

	Part of Body	Date	Number of Films	Shield Used
1.				
2.				
3.				

16) Do you smoke? Yes ☐ No ☐ _____

If yes, how many cigarettes per days? _____

17) Do you drink alcohol? Yes ☐ No ☐ _____

If yes, how many drinks per day / week? _____

18) Do you use any ilicit drugs? Yes ☐ No ☐ _____

If yes, what types? _____

19) List any concerns you have regarding this pregnancy?

_____

_____

_____

_____

_____

20) Are you interested in genetic testing even if you have no risk factors? Yes ☐ No ☐ _____

Name: _____

Address: _____ City: _____ State Florida

Birthday: _____ Phone Number _____ Zip Code: _____

Signature: _____