

PRENATAL/GENETIC SCREENING QUESTIONNAIRE

Dear Patient: in order to give you the best prenatal and/or genetic care and advice, please fill out the following questionnaire. These questions about family health apply to members in both your family and the baby's father's family. If you do not understand some of the questions, please mark them and ask the nurse/doctor when they interview you.

1. How old will you be when your baby is born? _____
2. Race of patient: (please circle) White Black Hispanic Asian Other: _____
3. Race of baby's father: (please circle) White Black Hispanic Asian Other: _____

Please circle YES or NO in answer to the following:

4. Do you, or the baby's father, have any close relatives descended from Jewish people who lived in Eastern Europe (Ashkenazic Jews)? **YES NO**
5. Have you, the baby's father, or any close relative been screened for sickle cell trait? **YES NO**
If yes, give results: _____
6. If you, or the baby's father, are of Italian or Greek (Mediterranean) ancestry, have either of you, or any close relatives, been screened for anemia? (Cooley's, Beta Thalassemi)? **YES NO**
If yes, give results: _____
7. In either family, has any doctor told you there is a genetic, chromosomal, or inherited problem? **YES NO**
8. Does anyone in either family have Spina Bifida (open spine), Hydrocephalus (water head) or anencephaly (part of the brain did not develop)? **YES NO**
9. Does anyone have problems with their muscles, such as muscle weakness, muscular dystrophy, or Duchenne's muscular dystrophy? **YES NO**
10. Does anyone have Down's Syndrome (Mongoloid)? **YES NO**
11. Is there any close relative who is mentally retarded? **YES NO**
12. Is there anyone with a bleeding problem – free bleeder or hemophiliac? **YES NO**
13. Has any female relative had three or more miscarriages? **YES NO**
14. Is there any other family health problem that you are worried your baby might have? **YES NO**
15. If you use any of the following, please fill out where applicable:

| | Frequency | Amount Each time | When last used |
|------------------------------|-----------|------------------|----------------|
| Caffeine | | | |
| Cigarettes | | | |
| Alcohol (Beer, Wine, Liquor) | | | |
| Marijuana | | | |
| Cocaine | | | |
| Any other drugs | | | |

Nurse/Physician Signature

Patient's Signature