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Prenatal Genetic Screen

Name:____ Date of Birth:____________________

1. Your age: __________ Baby's Father's age:____________
2. Number of pregnancies you have had: ________

   Full term: ________________ Premature: ________________ Miscarriages or abortions: ________________
3. Have you, the baby's father, or anyone in either of your families ever had any of the following disorders?

   Down's Syndrome (Mongolism) .... Yes ◯ No ◯
   Other chromosomal abnormality........ Yes ◯ No ◯
   Neural tube defect, i.e., spina bifida (meningomyelocele or open spine), anencephaly .... Yes ◯ No ◯
   Hemophilia........ Yes ◯ No ◯
   Muscular Dystrophy........ Yes ◯ No ◯
   Cystic Fibrosis .... Yes ◯ No ◯
4. Do you or the baby's father have a birth defect? .... Yes ◯ No ◯

   If yes, who had the defect and what is it? ____________________________
5. In any previous marriage, have you or the baby's father had a child, born dead or alive, with a birth defect not listed in question #2 above?........ Yes ◯ No ◯

   If yes, what was the defect and who had it? ____________________________
6. Do you or the baby's father have any close relatives with mental retardation?........ Yes ◯ No ◯

   If yes, indicate the relationship or the affected person to you or to the baby's father: ________________

   Indicate the cause, if known: ____________________________
7. Do you, the baby's father, or a close relative in either of your families have a birth defect, any familial disorder, or a chromosomal abnormality not listed above?........ Yes ◯ No ◯

   If yes, indicate the condition and the relationship of the affected person to you or to the baby's father:________________

   ____
8. In any previous marriage, have you or the baby's father had a stillborn child or three or more first-trimester spontaneous pregnancy losses? .... Yes ◯ No ◯

   Have either of you had a chromosomal study........ Yes ◯ No ◯

   If yes, indicate who and the results: ____________________________

9. If you or the baby's father are of Jewish ancestry, have either of you been screened for Tay-Sachs disease?........ Yes ◯ No ◯ Not applicable ◯

   If yes, indicate who and the results: ______________________________

10. If you or the baby's father are Black, have either of you been screened for sickle cell trait? .... Yes ◯ No ◯ Not applicable ◯

11. If you or the baby's father are of Italian, Greek, or Mediterranean background, have either of you been tested for B-thalassemia?........ Yes ◯ No ◯ Not applicable ◯

   If yes, indicate who and the results: ______________________________

12. If you or the baby's father are of Philippine or Southeast Asian ancestry, have either of you been tested for A-thalassemia?........ Yes ◯ No ◯ Not applicable ◯

   If yes, indicate who and the results: ______________________________

13. Excluding iron and vitamins, have you taken any medication or recreational drugs since being pregnant or since your last menstrual period (include non-prescription drugs)? .... Yes ◯ No ◯

   If yes, give name of medication and time taken during pregnancy: ______________________________

14. Are you immune to Rubella (3 day measles) or have you received the vaccination? .... Yes ◯ No ◯

15. Is there a family history of twins or triplets?........ Yes ◯ No ◯

   If so, who had them? ______________________________

16. Do you or your husband have a history of:........ Genital Herpes ◯ Genital Warts ◯ Gonorrhea ◯ Chlamydia ◯ Syphilis ◯ HIV (AIDS) ◯

17. Do you smoke?........ Yes ◯ No ◯ If so, how much? ______________________________

18. Do you drink alcohol? .... Yes ◯ No ◯ If so, how much? ______________________________

19. Do you have a cat?........ Yes ◯ No ◯

20. Alpha-Feto Protein/Triple Screen is a blood test available to screen for open Neural Tube Defects (Spina Bifida) and Down's syndrome in your baby. It is usually obtained between 15-18 weeks of pregnancy. This is a screening test and will not determine all cases of Down's or Neural Tube Defects. Also, if the test is positive, this does not necessarily mean your baby has a problem, but may benefit from additional testing. Please read the enclosed ACOG patient education pamphlet.

   Do you desire this screening test? Please initial __________ Yes ◯ No ◯

21. HIV (AIDS) testing is a routine part of our lab prenatal profile blood work. If you do not wish to be tested, you must sign a request for such prior to your labs being done.

22. Health Families Program (PACT) Are you interested in more information? Please initial __________ Yes ◯ No ◯

Patient's Signature ______________________________ Date ______________________________