Prenatal Genetic Screen- Southeast Women's Center

Name_____ Patient #_____ Date_____

1. Will you be 35 years or older when the baby is due? Yes__ No___
2. Have you, the baby's father, or anyone in either of your families ever had any of the following disorders?
   Down 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___
   If yes, indicate the relationship of the affected person to you or the baby's father.
   _____
3. Do you or the baby's father have a birth defect? Yes___No___
   If yes, who has the defect and what is it?_____
4. In any previous marriages, 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___
5. Do you or the baby's father have any close relatives with mental retardation? Yes___No___
   If yes, indicated the relationship of the affected person to you or to the baby's father:_____
   Indicate the cause, if known:_____
6. 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:_____
7. 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___
8. If you or the baby's father is of Jewish ancestry, have either of you been screened for Tay-Sachs disease, Canavan disease, or cystic fibrosis? Yes___No___
   If yes, indicated who and the results:_____
9. If you or the baby's father is black, have either of you been screened for sickle cell trait? Yes___No___
   If yes, indicate who and the results:_____
10. If you or the baby's father is of Italian, Greek, or Mediterranean background, have either of you been tested for B-thalassemia? Yes___No___
    If yes, indicated who and the results:_____
11. If you or the baby's father is of Philippine or Southeast Asian ancestry, have either of you been tested for a-thalassemia? Yes___No___
    If yes, indicate who and the results:_____
12. Irrespective of ethnic group, have you or the baby's father been screened for cystic fibrosis? Yes___No___
13. Excluding iron and vitamins, have you taken any medications or recreational drugs since becoming pregnant or since your last menstrual period? (include nonprescription drugs) Yes___No___
    If yes, give name of medication and time taken during pregnancy:_____
    _____
14. Have you currently been taking folic acid supplements? Yes___No___