

Perinatal Associates of Sacramento
Prenatal Genetic Screening Questionnaire

I. Mother of Pregnancy

Name _____
 Birthdate _____ Age at due date _____
 Ethnic Origin _____
 Occupation _____

Father of Pregnancy

Name _____
 Birthdate _____ Age at due date _____
 Ethnic Origin _____
 Occupation _____

Is your family or your baby's father's family... **No** **Yes**

from Southeast Asia, Taiwan, China, or the Philippines?

from the Middle East, Italy, Greece, or elsewhere in the Mediterranean region?

from India, Myanmar (Burma), Sri Lanka (Ceylon), Pakistan, or Afghanistan?

African or African-American (Black)?

Jewish and from Central or Eastern Europe?

Cajun or French Canadian?

II. Health information about you and your baby's father

Has either of you had major surgery or a serious medical problem (such as diabetes, seizures)?

Was this pregnancy achieved through in-vitro fertilization (IVF) or other assisted reproductive methods?

Are you and the baby's father related except by marriage (for example, as first cousins)?

Are you or the baby's father adopted?

If yes to any of the above, please explain: _____

III. During this pregnancy have you had or used...

	No	Yes		No	Yes
First Trimester screening	<input type="checkbox"/>	<input type="checkbox"/>	Any injuries or accidents	<input type="checkbox"/>	<input type="checkbox"/>
Quad marker (AFP) screening	<input type="checkbox"/>	<input type="checkbox"/>	Prenatal Vitamins	<input type="checkbox"/>	<input type="checkbox"/>
Ultrasound	<input type="checkbox"/>	<input type="checkbox"/>	Medications	<input type="checkbox"/>	<input type="checkbox"/>
Radiation (X-rays)	<input type="checkbox"/>	<input type="checkbox"/>	Cigarettes	<input type="checkbox"/>	<input type="checkbox"/>
Bleeding or Spotting	<input type="checkbox"/>	<input type="checkbox"/>	Alcohol	<input type="checkbox"/>	<input type="checkbox"/>
Other (please specify above)	<input type="checkbox"/>	<input type="checkbox"/>	Drugs (cocaine, marijuana, etc)	<input type="checkbox"/>	<input type="checkbox"/>

If yes to any of the above, please explain _____

IV. In your family or your baby's father's family, has anyone ever had...

	Don't Know	No	Yes		Don't Know	No	Yes
Down syndrome	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Tay Sachs or Canavan	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Another chromosome abnormality	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Cystic fibrosis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Open spina bifida or anencephaly	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Kidney disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
A heart defect	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Hemochromatosis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cleft lip or palate	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Sickle cell anemia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Any other birth defect	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Thalassemia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Mental retardation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Muscular dystrophy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes (high blood sugar)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Neurofibromatosis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Blood clots in the arms or legs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Any nerve/muscle disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
A stroke at less than 50 years old	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Two or more miscarriages	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Heart problems at less than 50 years old	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	A stillbirth	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cancer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	A childhood death	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Do you or the baby's father have concerns about any other condition in either of your families? If so, please explain: _____

Filled out by: _____

Date: _____

Reviewed by: _____

Date: _____