Print Name:_____

Date of Birth:_____

Date:_____

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Genetic History Questionnaire for Prenatal Patients

The answers to these questions will help in the care of your pregnancy. Please answer these questions as well as you can, all answers will remain private.

1. Is your family…

   From Southeast Asia, Taiwan, China, or the Philippines? ☐ No ☐ Yes ☐ Not Sure

   From Italy, Greece, or the Middle East? ☐ No ☐ Yes ☐ Not Sure

   African American (Black)? ☐ No ☐ Yes ☐ Not Sure

   Hispanic/Puerto Rican? ☐ No ☐ Yes ☐ Not Sure

2. Is your family, or your baby's paternal father's family European (Ashkenazi) Jewish?

   ☐ No ☐ Yes ☐ Not Sure

The next nine questions will be about you, your baby's paternal father and both of your families. When we reference "blood relative" we mean your child (or unborn baby), mother, father, sister, brother, grandparent, aunt, uncle, niece, nephew, or cousin.

3. Were you, or your baby's paternal father or any blood relative born with an opening in the back or spine, also called Spina Bifida or who had an opening in the head, also called Anencephaly?

   ☐ No ☐ Yes ☐ Not Sure

4. Is any blood relative in your family or your baby's paternal father's family developmentally delayed?

   ☐ No ☐ Yes ☐ Not Sure

5. Have you, or your baby's paternal father, or any blood relative had an unborn baby or a child who had Down Syndrome, also referred to Trisomy 21? ☐ No ☐ Yes ☐ Not Sure

6. Do you, or your baby's paternal father, or any blood relative have any other chromosomal problems?

   ☐ No ☐ Yes ☐ Not Sure

Ask your health care provider about multiple marker screening for Down Syndrome, Spina Bifida, and Trisomy 18, even if there is NO history of these in your or your baby's father's family.

7. Do you, or does your baby's paternal father, or any blood relative have any of the following:
   a. Cystic Fibrosis (CF)? ☐ No ☐ Yes ☐ Not Sure
   b. Fragile X Syndrome? ☐ No ☐ Yes ☐ Not Sure
   c. Muscular Dystrophy? ☐ No ☐ Yes ☐ Not Sure
   d. Hemophilia or other bleeding disorder? ☐ No ☐ Yes ☐ Not Sure
   e. Huntington disease? ☐ No ☐ Yes ☐ Not Sure

Continue to other side →

8. Were you, or your baby's paternal father, or any blood relative born with any of the following:
    a. A heart defect? ☐ No ☐ Yes ☐ Not Sure
    b. A cleft lip and/or cleft palate? ☐ No ☐ Yes ☐ Not Sure
    c. Any other birth defect? ☐ No ☐ Yes ☐ Not Sure
9. Have you ever had any of the following:
    a. Two or more miscarriages? ☐ No ☐ Yes
    b. A stillborn baby **and** one or more miscarriage(s) ☐ No ☐ Yes
10. Do you, or your baby's paternal father, or any blood relative have any other disease or health problem that is inherited (passed on in the family)? ☐ No ☐ Yes ☐ Not Sure

The next two questions will be about medical conditions that you (the patient) may have.

11. Do you have, or have you ever been treated for PKR (Phenylketonuria) or Hyperphenylalaninemia (Hyperphe)? ☐ No ☐ Yes ☐ Not Sure
12. During this pregnancy, have you taken any of the following:
    a. Seizure medications? (Dilantin, Valproic acid, Depakene, Tegretol, Atretol, Mysoline, Tridione) ☐ No ☐ Yes
    b. Lithium for bipolar disorder or depression (Eskalith, Lithobid, Lithonate)? ☐ No ☐ Yes
    c. Medication for Acne (Accutane, Isotretinoin) ☐ No ☐ Yes
    d. Chemotherapy/immunosuppressive medication (Methotrexate, aminopterin, rheumatrex) ☐ No ☐ Yes

Provider Signature:_____ Date: _____