REITER, HILL, JOHNSON & NEVIN

GENETIC SCREENING QUESTIONNAIRE

Patient Name: _____ Race/Ethnicity: _____ Age: _____

Partner Name: _____ Race/Ethnicity: _____ Age: _____

1. **Will you be 35 years of age or older when the baby is due?** ☐ **YES** ☐ **NO**

2. **Have you, the baby's father or anyone in either family ever had:** ☐ **YES** ☐ **NO**
   Down Syndrome, Other Chromosomal Abnormalities, Neural Tube Defects (Spina Bifida, Anencephaly), Hemophilia, Muscular Dystrophy, Cystic Fibrosis, Mental Retardation or Other Familiar Disorders
   If yes, please describe: _____

3. **Do either you or the baby's father have a birth defect (including heart defects)?** ☐ **YES** ☐ **NO**
   If yes, please describe: _____

4. **Have you or the baby's father had a child born dead or alive with a birth defect not listed above?** ☐ **YES** ☐ **NO**
   If yes, please describe: _____

5. **Do you or the baby's father have a history of a stillborn child or three or more miscarriages?** ☐ **YES** ☐ **NO**
   If yes, please describe: _____

6. **Are you or the baby's father of Jewish ancestry?** ☐ **YES** ☐ **NO**
   If yes, have either of you been screened for Tay Sachs, Gaucher or Canavan? _____
   If so, please describe: _____

7. **Are you or the baby's father African American?** ☐ **YES** ☐ **NO**
   If yes, have either of you been screened for sickle cell? _____
   If so, please describe: _____

8. **Are you or the baby's father of Mediterranean ancestry or Southeast Asian ancestry?** ☐ **YES** ☐ **NO**
   If yes, have either of you been screened for anemia/thalassemia? _____
   If so, please describe: _____

9. **Do you or any member of your family have a history of premature ovarian failure, Fragile X, autism or unexplained mental retardation?** ☐ **YES** ☐ **NO**
   If yes, please describe: _____

10. **I have received information on Cystic Fibrosis screening.** ☐ **YES** ☐ **NO**

_____ _____

Patient Signature Date

REITER, HILL, JOHNSON & NEVIN

OB MEDICAL UPDATE

Patient Name: _____ Date: _____

1. Please ☑ any of the below condition(s) that you have or have had in the past:

☐ Cancer	☐ Headaches	☐ Bowel Disease	☐ Gynecological Infections
☐ HIV/AIDS	☐ Asthma	☐ Heart Disease	☐ Group B Strep Carrier
☐ Diabetes	☐ Hepatitis	☐ Kidney Disease	☐ Von Willebrands/Bleeding Disorder
☐ Epilepsy	☐ High Blood Pressure	☐ Eating Disorder	☐ Recurrent Urinary Tract Infections
☐ Herpes	☐ Depression	☐ LEEP/Cone Biopsy	☐ Incompetent Cervix/Previous D & C's
☐ Anemia	☐ Thyroid Disorder	☐ Clotting Disorder	☐ Arthritis/Lupus/Connective Tissue Disease

Please describe: _____

2. Please list any prior surgeries that you have had: _____

3. Are you allergic to any medications? ☐ **YES** ☐ **NO**
If yes, please list medicine and reaction: _____

4. Have you taken any medications (prescriptions, over-the-counter or herbal) since your last menstrual period? ☐ **YES** ☐ **NO**
If yes, please list: _____

5. Do you smoke cigarettes? ☐ **YES** ☐ **NO**

6. Do you drink alcoholic beverages? ☐ **YES** ☐ **NO**

7. Do you use any recreational drugs? ☐ **YES** ☐ **NO**

8. Have you been exposed to chemicals or radiation (i.e. X-rays) since your last menstrual period? ☐ **YES** ☐ **NO**

9. Do you or any family member have a history of problems with anesthesia? ☐ **YES** ☐ **NO**
If yes, please describe: _____

10. Do you have any religious objections to any form of medical treatment including blood transfusions? ☐ **YES** ☐ **NO**

11. Do you own or take care of cats? ☐ **YES** ☐ **NO**

12. Do you have any family members with a history of blood clotting disorders? ☐ **YES** ☐ **NO**

13. Do you work with elementary or preschool children? ☐ **YES** ☐ **NO**

_____ _____
Patient Signature Date