

Name: _____ Date of Birth: _____

Prenatal Genetic Screen

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 affect 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	Yes _____	No _____
Genital Warts	Yes _____	No _____
Gonorrhea	Yes _____	No _____
Chlamydia	Yes _____	No _____
Syphilis	Yes _____	No _____
HIV (AIDS)	Yes _____	No _____

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? Yes _____ No _____
Please circle and initial _____

Patient's Signature _____ Date _____