

Genetic Questionnaire — Women's Clinic

Name _____ Race _____ Religion _____

Will you be 35 years or older when the baby is born? Yes No

Have you had a previous child with a genetic abnormality? Yes No

If yes, what was the abnormality? _____

Do you or the baby's father have a birth defect? Yes No

If yes, who has the defect and what is it? _____

Have you, the baby's father, or anyone in either of your families ever had any of the following disorders:

	You	Your Family	Baby's Father	Father's Family	No
Down Syndrome	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Neural tube defect (spina bifida, anencephaly)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Hemophilia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Muscular Dystrophy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cystic Fibrosis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Tay-Sachs (especially Jewish or French Canadian)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sickle cell trait/disease (especially African-American)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
B-thalassemia (especially Italian/Greek/Mediterranean)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
D-thalassemia (especially Southeast Asian/Chinese)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Congenital heart disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Fragile X	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cleft lip/cleft palate	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Mental retardation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Do you, the baby's father or anyone in either of your families have a genetic disorder not listed above? Yes No

If yes, which disorder? _____ Who has it? _____

Excluding vitamins and iron, have you taken any medications or recreational drugs since becoming pregnant or since your last menstrual period? Yes No

If yes, give the name of the drug and when taken: _____

I certify that the above answers are correct to the best of my knowledge.

Signature

Date