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Prenatal Genetic Screen

Name _____ Patient # _____ Date ____/____/____

1. Will you be 35 years or older when the baby is due? Yes _____ No _____
2. Have you, the baby's father, or anyone in either of your families ever had any of the following disorders?
 - Down 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 _____
 If yes, indicate the relationship of the affected person to you or to the baby's father: _____
3. Do you or the baby's father have a birth defect? Yes _____ No _____
 If yes, who has the defect and what is it? _____
4. In any previous marriages, 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? _____
5. Do you or the baby's father have any close relatives with mental retardation? Yes _____ No _____
 If yes, indicate the relationship of the affected person to you or the baby's father: _____
 Indicate the cause, if known: _____
6. 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: _____
7. In any previous marriages, 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: _____

8. Are you or the baby's father of Jewish ancestry? Yes _____ No _____
 If yes, have either of you been screened for Tay-Sachs Disease? Yes _____ No _____
9. Are you or the baby's father of African American ancestry? Yes _____ No _____
 If yes, have either of you been screened for sickle cell trait? Yes _____ No _____
10. Are you or the baby's father of Italian, Greek, or Mediterranean background? Yes _____ No _____
 If yes, have either of you been tested for B-thalassemia? Yes _____ No _____
11. Are you or the baby's father of Philippine or Southeast Asian ancestry? Yes _____ No _____
 If yes, have either of you been tested for a-thalassemia? Yes _____ No _____
12. Excluding iron and vitamins, have you taken any medication or recreational drugs since being pregnant or since your last menstrual period? (include nonprescription drugs). Yes _____ No _____
 If yes, give name of medication and time taken during pregnancy: _____

FOR OFFICE USE ONLY

ACOG Screening for Birth Defects Literature given _____
 ACOG Cystic Fibrosis Lit given _____
 ACOG Amnio/CVS Lit given _____
 Welcome Packet and Information given _____
 TX DSHS Cord blood literature given _____