

PRENATAL GENETIC SCREEN

Name: _____ Date: _____

Date of Birth: _____

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?

| | <u>Patient</u> | <u>Baby's Father</u> | <u>Family</u> | <u>None</u> |
|--------------------------------------------------------------------------------------------|----------------|----------------------|---------------|-------------|
| Autism | _____ | _____ | _____ | _____ |
| Canavan Disease | _____ | _____ | _____ | _____ |
| Congenital Heart Defect | _____ | _____ | _____ | _____ |
| Cystic Fibrosis | _____ | _____ | _____ | _____ |
| Down Syndrome (Mongolism) | _____ | _____ | _____ | _____ |
| Hemophilia/Other Blood disorders | _____ | _____ | _____ | _____ |
| Huntington's chorea | _____ | _____ | _____ | _____ |
| Metabolic disorder | _____ | _____ | _____ | _____ |
| Muscular Dystrophy | _____ | _____ | _____ | _____ |
| Neural tube defect, i.e., Spina Bifida (meningomyelocele or open spine), anencephaly | _____ | _____ | _____ | _____ |
| Other chromosomal abnormality | _____ | _____ | _____ | _____ |
| PKU | _____ | _____ | _____ | _____ |

If a family member is affected, indicate the relationship of the affected person to you or 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 is/was the defect? _____

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: _____
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 the baby's father: _____

(over)

7. Have you had three or more miscarriages or any stillborn births? Yes ___ No ___
 Have you had a chromosomal study? Yes ___ No ___
 If yes, indicate the results. _____
8. In any previous relationships, did the baby's father have three or more miscarriages
 or any stillborn births? Yes ___ No ___
 Has he had a chromosomal study? Yes ___ No ___
 If yes, indicate the results. _____
9. Are you or the baby's father of Jewish descent? Yes ___ No ___
 If yes, have either of you been screened for Tay-Sachs disease? Yes ___ No ___
 If yes, indicate the results. _____
10. Are you or the baby's father of African/African-American descent? Yes ___ No ___
 If yes, have either of you been screened for sickle cell trait? Yes ___ No ___
 If yes, indicate the results. _____
11. Are you or the baby's father of Italian, Greek or Mediterranean descent?
 Yes ___ No ___
 If yes, have either of you been tested for B-thalassemia? Yes ___ No ___
 If yes, indicate the results. _____
12. Are you or the baby's father of Philippine or Southeast Asian descent?
 Yes ___ No ___
 If yes, have either of you been tested for A-thalassemia? Yes ___ No ___
 If yes, indicate the results. _____
13. Are you or the baby's father a Jehovah's Witness? Yes ___ No ___
14. Have you had a cesarean section? Yes ___ No ___
 If yes, what was the reason: _____
 If yes, will you attempt a vaginal birth
 with this pregnancy? Yes ___ No ___
 Don't know _____
15. Excluding iron or prenatal vitamins, have you taken any
 drugs (including alcohol) since being pregnant or since your last
 menstrual period? Yes ___ No ___
 If yes, give name of medication/drug and time taken
 during pregnancy: _____
16. Are you up to date with immunizations? Yes ___ No ___
17. Have you had chicken pox? Yes ___ No ___
18. Have you recently (within the last 12 weeks) traveled to a Zika-
 affected area? Yes ___ No ___
19. Do you have symptoms associated with Zika virus (fever, rash,
 joint pain, or conjunctivitis)? Yes ___ No ___

Signed: _____

Date: _____