

Name: _____

Date: _____

PRECONCEPTION/GENETIC QUESTIONNAIRE

Please circle Y or N

1. If you are now pregnant, will you be 35 years or older when this child is due? _____ Y N

2. Please indicate if you, your partner/husband, or anyone in either of your families have had any of the following:

- | | | | | |
|---|---|---|---|---|
| a. 2 or more miscarriages | Y | N | | |
| b. A child with a birth defect | Y | N | | |
| c. Down syndrome or other chromosome abnormality | Y | N | | |
| d. Muscular dystrophy or other neuromuscular disorder | Y | N | | |
| e. Hemophilia or other bleeding disorders | | | Y | N |
| f. Cystic fibrosis | Y | N | | |
| g. Neural tube defect (such as spina bifida, anencephaly) | Y | N | | |
| h. Mental retardation | | | Y | N |

3. Do you or your partner/husband have any chronic medical conditions such as diabetes, PKU, or lupus? If yes, please indicate condition: _____ Y N

4. Are you or your partner/husband of Ashkenazi Jewish descent? _____ Y N

If yes, have you/your partner been screened for carrier status? _____ Y N

If yes, when and where was screening done? _____

5. Are you or your partner African American or of African descent? _____ Y N

If yes, have you/your partner been screened for Sickle Cell disease? _____ Y N

6. Are you or your partner of Southeast Asian or Philippine descent? _____ Y N

If yes, have you been screened for Thalassemia? _____ Y N

7. Are you or your partner of Greek or Italian descent? _____ Y N

If yes, have you been screened for Thalassemia? (Mediterranean Anemia) _____ Y N

8. Do you currently take any medications either prescribed or not prescribed? _____ Y N

If yes, please list: _____ Y N

9. Do you use any recreational drugs? _____ Y N

If yes, please indicate which drugs and how often _____

10. Are you exposed to any chemical agents either in your workplace or at home? _____ Y N

If yes, please indicate type of exposure and/or occupation _____

11. Do you drink alcohol? _____ Y N

If yes, please describe how often and amount: _____

12. Do you or your partner smoke cigarettes? _____ Y N

13. Have you ever been tested to determine if you are immune to Rubella (German Measles)? If yes, list where tested and results: _____ Y N

14. Do you own cats? _____ Y N

16. Do you eat rare or raw meat? (sushi is not meat) _____ Y

N _____

17. Have you had chicken pox? _____ Y N

18. Do you or your partner have a history of genital herpes? _____ Y N

19. Do you or your partner have a family history of a genetic condition or birth defect not mentioned above? If yes, please describe: _____ Y N

Recommendations:

Created on 8/31/04

