women's center for health

GENETIC DATA (PAGE 1/2)

please PRINT all information clearly

Patient's Name ______________________ Physician ______________________

SCREENING QUESTIONNAIRE

	YES	NO
1. Will you be age 35 or older when you have children?	☐	☐
2. Have you or your partner or anyone in either of your families ever had:	☐	☐
a) Down's Syndrome (mongolism)?	☐	☐
b) Spina Bifida or Meningomyelocele (open spine)?	☐	☐
c) Hemophilia?	☐	☐
d) Muscular Dystrophy?	☐	☐
e) Cystic Fibrosis	☐	☐
f) Spinal Muscular Atrophy (SMA)?	☐	☐
g) Fragile X Disease?	☐	☐
3. Have you or your partner ever had a child born dead or alive with a birth defect not listed in Question 2 above? If YES, describe: ______________________	☐	☐
4. Do you or your partner have any close relatives who are mentally retarded, have birth defects, or Autism? If YES, describe: ______________________	☐	☐
5. Do you or your partner or a close relative in either family have any inherited genetic or chromosomal disease or disorder not listed above? If YES, describe: ______________________	☐	☐
6. Have you or your partner had three or more spontaneous pregnancy losses, miscarriages, stillbirths, etc.?	☐	☐

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GENETIC DATA (PAGE 2/2)

SCREENING QUESTIONNAIRE

	YES	NO
7. Do you or your partner have any close relatives descended from Jewish people who lived in Eastern Europe (Ashkenazi Jews)?	☐	☐
If YES, have either of you been tested for Tay-Sachs disease?	☐	☐

If YES, indicate results and who was screened: ____________________

____

	YES	NO
8. Are you or your partner African American?	☐	☐
If YES, have either you or your partner, or any close relative, ever been screened for sickle cell trait and found to be positive?	☐	☐

If YES, indicate results and who was screened: ____________________

____

	YES	NO
9. Do you or your partner have any close relatives descended from Mediterranean countries?	☐	☐
If YES, have you or your partner been screened for thalassemia (Cooley's Anemia)?	☐	☐

If YES, indicate results and who was screened: ____________________

____

	YES	NO
10. Do you drink alcoholic beverages?	☐	☐

If YES, describe how often and amount: ____________________

	YES	NO
11. Do you take any medications either by prescription or those which can be purchased over the counter in a drug store? If YES, please list drugs and dosage schedule: ____________________	☐	☐

____

	YES	NO
12. Have you ever been tested to determine if you are immune to Rubella (German Measles)? If YES, indicate where and when tested and results of test: ____________________	☐	☐

____

Patient's Signature ____________________ Date ____________________