

PRENATAL GENETIC SCREENING QUESTIONNAIRE

Patient's Name _____

Date of Birth _____

Doctor / Clinic _____

Today's Date _____

The following questionnaire will help evaluate the health of your unborn baby. Your answers may indicate that certain tests would be appropriate. Please answer all questions as completely as possible. All information will be kept confidential.

1. Will you be 35 or older at your due date? Yes No Your due date is _____

2. Are you OR the baby's father from any of these ethnic backgrounds?

Italian, Greek, Middle Eastern, Spanish, Southern Chinese, Asian Indian, Taiwanese, Filipino, or Southeast Asian

Yes No Don't know

If yes, have you or the baby's father been tested to see if you are a carrier of thalassemia or other hemoglobin abnormality?

Yes No Don't know

If yes, who was tested and what were the results? _____

3. Have you, the baby's father, or any relative had a neural tube defect (such as open spine, spina bifida, anencephaly)?

Yes No Don't know

If yes, please write the diagnosis or describe the defect. _____

How is the person related to you or the baby's father? _____

4. Have you, the baby's father, or anyone in your families been born with a heart defect?

Yes No Don't know

If yes, please write the diagnosis or describe the defect. _____

How is the person related to you or the baby's father? _____

5. Have you, the baby's father, or anyone in your families had a pregnancy or a child diagnosed with Down syndrome?

Yes No Don't know

If yes, how is this person related to you or the baby's father? _____

6-7. Are you, or the baby's father, of Jewish or French Canadian / Cajun background?

Yes No Don't know

If yes, have either you or the baby's father been tested to see if you are carriers of Tay-Sachs disease, cystic fibrosis, or Canavan disease?

Yes No Don't know

If yes, who was tested and what were the results? _____

8A. Are you, or the baby's father, African-American or of African descent? Yes No

8B. Are you, or the baby's father, of Hispanic descent? Yes No

If yes, to either A or B, have either you or the baby's father been tested to see if you have sickle cell trait (are a carrier of sickle cell anemia)?

Yes No Don't know

If yes, who was tested and what were the results? _____

9. Do you, the baby's father, or anyone in your families have hemophilia or another bleeding disorder?

Yes No Don't know

If yes, please write the diagnosis or describe the disorder. _____

How is the person related to you or the baby's father? _____

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10. Do you, the baby's father, or anyone in your families have a neuromuscular disease or muscular dystrophy?

Yes No Don't know

If yes, please write the diagnosis or describe the disease. _____

How is the person related to you or the baby's father? _____

11. Do you, the baby's father, or anyone in your families have cystic fibrosis?

Yes No Don't know

If yes, how is this person related to you or the baby's father? _____

12. Do you, the baby's father, or anyone in your families have Huntington's disease?

Yes No Don't know

If yes, how is this person related to you or the baby's father? _____

13. Do you, the baby's father, or anyone in your families have autism, mental retardation or Fragile X?

Yes No Don't know

If yes, please write the diagnosis or describe the problem. _____

How is this person related to you or the baby's father? _____

14. Do you, the baby's father, or anyone in your families have an inherited disorder or chromosomal abnormality not listed above?

Yes No Don't know

If yes, please write the diagnosis or describe the problem. _____

How is this person related to you or the baby's father? _____

15. Do you have insulin dependent diabetes, PKU, lupus, or another chronic condition? Yes No

If yes, please write the diagnosis. _____

16. Do you, the baby's father, or anyone in your families have a birth defect not listed above?

Yes No Don't know

If yes, please write the diagnosis or describe the defect. _____

How is the person related to you or the baby's father? _____

17. Have you or the baby's father had a stillborn child or two or more pregnancy losses in this or any other relationship?

Yes No Don't know

If yes, please describe. _____

18. Have you taken any medications, recreational drugs, or had any alcoholic drinks since your last menstrual period, or had any rashes or infectious diseases?

Yes No Don't remember If yes, please describe. _____

19. Did you, the baby's father, or anyone in your families have any other serious medical condition in infancy or childhood?

Yes No Don't know

If yes, please describe. _____

How is the person related to you or the baby's father? _____

I have answered these questions to the best of my knowledge _____

Patient Signature

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Reviewed by: _____

Date: _____

