Lifespan Physician Group, Inc. - Obstetrics & Gynecology
Prenatal Genetic Screening Questionnaire

Legal Name _____ Date of birth _____
Preferred Name _____ Pronouns_____
Your Occupation _____ How old will you be when the baby is born? _____
Partner Name _____ Date of Birth _____ Occupation _____

Family and Patient History

1. Is your family or your baby's father's family…	**You**	**Partner**
a. From Southeast Asia, Taiwan, China, or the Philippines?	No __ Yes __	No __Yes __
b. From Italy, Spain, Portugal, Greece, or the Middle East?	No __ Yes __	No __Yes __
c. From Africa or African-American (Black)?	No __ Yes __	No __Yes __
d. Central Eastern European (Ashkenazi) Jewish?	No __ Yes __	No __Yes __
e. Cajun, French Canadian or Irish?	No __ Yes __	No __Yes __

2. Have you or the baby's father or any close relatives (child, mother, father, sister, brother, aunt, uncle or grandparent) in either of your families ever had any of the following disorders?

a. Down syndrome	No __Yes __	j. Muscular dystrophy	No __Yes __
b. Other chromosomal abnormalities	No __Yes __	k. Nerve or muscle disorder	No __Yes __
c. Neural tube defect (spina bifida)	No __Yes __	l. Bone or skeletal disorder	No __Yes __
d. Bleeding disorder (hemophilia)	No __Yes __	(dwarfism)	
e. Cystic fibrosis	No __Yes __	m. Polycystic kidney disease	No __Yes __
f. Sickle Cell Anemia	No __Yes __	n. Heart defect (at birth)	No __Yes __
g. Thalassemia (Mediterranean anemia)	No __Yes __	o. Cleft lip/palate	No __Yes __
h. Tay-Sachs/Canavan disease	No __Yes __	p. Phenylketonuria (PKU)	No __Yes __
i. Neurofibromatosis	No __Yes __		

3. Are you and the baby's father related by blood, for example, cousins? ..... No __Yes __
4. Do you or the baby's father have any close relatives with mental retardation?..... No __Yes __
   A. What was the cause, if known? _____.
5. Do you or the baby's father have any close relatives with autism?..... No __Yes __
6. Do you, the baby's father, or a close relative in either of your families have a genetic condition or chromosomal abnormality not listed above? ..... No __Yes __
7. Do you, the baby's father, or a close relative in either of your families have a birth defect not listed above?..... No __Yes __
8. Do you, the baby's father, or a close relative in either of your families have a serious medical problem that you are concerned about (such as diabetes)?..... No __Yes __
9. Have you or the baby's father had a baby who died shortly after birth or in the first year? No __Yes __
10. Have you or the baby's father had a stillborn child, or two or more first trimester spontaneous pregnancy losses? ..... No __Yes __
11. Excluding vitamins and iron, have you taken any medications, street drugs, or alcohol since being pregnant or since your last menstrual period? ……..... No __Yes __
12. Have you had any reproductive technology assistance (IUI, IVF, ICSI, PGD, donor)? No __Yes __
13. Since your last period, have you had any rashes or infectious diseases? No __Yes __
14. Since your last period, have you been exposed to any X-Rays or CT scans? No __Yes __
15. Have you or anyone in your family been diagnosed with a blood clot in your leg or your lungs? No __Yes __

16. If yes to any questions above, please explain:

_____

_____

Completed by _____ Date _____

Reviewed by _____ Date _____