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Medical Genetics Questionnaire

Having a baby is a special event. Once a baby is born, families take certain precautions to ensure the baby's health and safety. The unborn child deserves similar care. While most babies are born healthy, some babies can be born with a birth defect or develop a significant health problem after birth. Many of these problems occur despite the best prenatal care; however, some birth defects can be prevented, or at least detected, before birth with appropriate screening. This questionnaire is designed to identify certain factors in your family or medical history that may have an impact on your pregnancy outcome. It is important to answer all of the questions as completely as possible. You may need to discuss some of the questions with other family members to obtain additional information.

Past Pregnancy History

Counting this pregnancy, how many times have you been pregnant? _____

How many live-born babies have you had? _____

Are all of your live-born children still living? No___ Yes___

Have you or the baby's father ever had any of the following:

- Miscarriage? No___ Yes___
- Stillborn baby? No___ Yes___
- Children born with birth defects? (i.e.: spinal defect, down syndrome, heart defect, limb defect, etc.) No___ Yes___

Family History

Are you and the baby's father directly related to one another? (ie: cousins, siblings, etc.) No___ Yes___

Do you or the baby's father have a birth defect or genetic condition? No___ Yes___

Has anyone in you or your partner's family had: fragile X, MR, autism, developmental delay, or ovarian failure before age 40? No___ Yes___

If so, explain: _____

_____

Your Family

Is anyone in your family:

- Mentally retarded? No___ Yes___
- Had a child with a birth defect? No___ Yes___
- Had a condition that has been diagnosed as genetic or inherited? No___ Yes___

Are there any diseases that "run" in your family? No___ Yes___

Baby's Father's Family

How old is the baby's father? _____

Is anyone in his family:

- Mentally retarded? No___ Yes___
- Had a child with a birth defect? No___ Yes___
- Had a condition that has been diagnosed as genetic or inherited? No___ Yes___

Are there any diseases that "run" in his family? No___ Yes___

Are you or the baby's father of:

Eastern European Jewish origin (Ashkenazil)?	No___	Yes___
Italian, Greek or Mediterranean origin?	No___	Yes___
African origin (i.e.: Black American, Ethiopian, Haitian, Nigerian, West Indian, etc.)?	No___	Yes___
Philippine or Southeast Asian origin?	No___	Yes___
Alaskan Native, Oriental origin?	No___	Yes___

Testing

Have you or the baby's father been tested for:

Tay-Sachs disease?	No___	Yes___
B Thalassemia?	No___	Yes___
Sickle cell disease?	No___	Yes___
A Thalassemia?	No___	Yes___
Hepatitis?	No___	Yes___

If you answered YES to any of the above, please briefly explain: _____

_____

_____

Have you or your partner had herpes? No___ Yes___

Current Pregnancy

Will you be age 35 or older when the baby is born? No___ Yes___

Do you:

Smoke? No___ Yes___

Drink? No___ Yes___

If Yes, How many drinks does it take to make you feel high? ____

Have people annoyed you by criticizing your drinking? ____

Have you felt you ought to cut down on your drinking? ____

Have you ever had a drink first thing in the morning to steady your nerves

Or to get rid of a hangover? ____

Use "recreational" or "street" drugs? No___ Yes___

Do you have any chronic health problems? (i.e.: diabetes, heart disease, epilepsy, etc.) No___ Yes___

Do you have asthma? No___ Yes___

If so, what triggers it? _____

Have you ever needed:

Steroids? _____

Hospitalization or ER Visit? _____

Intubation? _____

Do you have a current physician that follows you? _____

Does it wake you up at night? _____

How often does it interfere with normal activity?_____

How many days per week? _____

Are you currently on "allergy shots"?_____

During this pregnancy have you ever had:

Any type of illness?	No___	Yes___
A high fever (102°F or greater)?	No___	Yes___

Do you take medications on a regular basis? No___ Yes___

If YES, are they:

Prescription? No___ Yes___

Non-prescription (over the counter) No___ Yes___

Were medications taken during this pregnancy? No___ Yes___

If you answered YES to any of the above, please list the medications: _____

_____

_____

Do you:

Take vitamins? No___ Yes___

Follow any special diet? (i.e.: vegetarian, macrobiotic, diabetic, etc.) No___ Yes___

Have you had any x-rays or any type of surgery during this pregnancy? No___ Yes___

Do you have any history of toxic chemical exposure? No___ Yes___

Have you or do you:

Recently emigrated from a country with high ambient lead levels? (e.g. where leaded gasoline is used or emissions are poorly controlled) ____

Live near a lead source? (e.g. lead mine or battery recycling plant) ____

Work with lead or live with someone who does? (e.g. lead, battery, paint, plastic, shipbuilding, or ammunition manufacturing) _____

Use lead-glazed ceramic pottery? ____

Engage in stained glass or pottery work in which leaded glazes or paints are used?_____

Have pica (eat non-food items such as soil)? ____

Use imported foods, spices, or supplements which may have been contaminated with lead? ____

Remodel homes where lead paint is disturbed? ____

Patient Name: _____ **DOB:** _____ **Date:** _____