# Center for Fetal Medicine and Women's Ultrasound

6310 San Vicente Suite 520, Los Angeles, Ca. 90048
Ph: (323) 857-1952 Fax: (323) 857-1804

**Patient Information**

Name ______________________________ Date of Birth ____________ Occupation ___________________

Address ________________________________________ City ________________ State _____ Zip ________

Home Phone _______________________________ Cell Phone ____________________________________

Referring Physician's Name _______________________ Physician Phone Number____________________

**Partner Information** (If pregnant, then "partner" is the genetic/biological father of the pregnancy)

Name ______________________________ Date of Birth ____________ Occupation ___________________

**The following questions will help your genetic counselor complete a genetic risk assessment and determine if certain tests are appropriate. If you are unsure about your family history, please speak with family members to obtain that information.**

| **Are you or your partner from any of these ethnic backgrounds? Please circle and check all that apply:** | **Yes** | **No** |
|---|---|---|
| Chinese, Southeast Asian, Taiwanese, Filipino, Pacific Islander, Pakistani or Asian Indian………………… | ☐ | ☐ |
| Spanish, Italian, Greek or Middle Eastern……………………………………………………………………… | ☐ | ☐ |
| Jewish, French Canadian or Cajun………………………………………………………………………………… | ☐ | ☐ |
| African American, African descent, Black, Puerto Rican, Caribbean or Central American…………………… | ☐ | ☐ |
| Hispanic or Mexican……………………………………………………………………………………………… | ☐ | ☐ |
| Caucasian……………………………………………………………………………………………………… | ☐ | ☐ |
| Other (specify)………………………………………………………………………………………………… | ☐ | ☐ |

**Have you, your partner, or anyone in your families ever had the following conditions:**

| | **Yes** | **No** | | **Yes** | **No** |
|---|---|---|---|---|---|
| Down syndrome………………………………… | ☐ | ☐ | Heart defect at birth……………………………… | ☐ | ☐ |
| Other chromosomal problem…………………… | ☐ | ☐ | Cleft lip/cleft palate……………………………… . | ☐ | ☐ |
| Mental retardation……………………………… | ☐ | ☐ | Blindness/deafness……………………………….. | ☐ | ☐ |
| Autism…………………………………………… | ☐ | ☐ | Baby who died after birth or within 1st yr………... | ☐ | ☐ |
| Spine bifida (open spine)……………………… | ☐ | ☐ | Stillborn or 2 or more pregnancy losses……….. | ☐ | ☐ |
| Anencephaly (opening in head/brain)………… | ☐ | ☐ | Any birth defect not listed above………………… | ☐ | ☐ |
| Blood disorder, ex: hemophilia or sickle cell…. | ☐ | ☐ | Any other inherited genetic condition…………... | ☐ | ☐ |
| Muscular dystrophy or neuromuscular disease…... | ☐ | ☐ | Any other serious medical condition or surgery.. | ☐ | ☐ |
| Cystic fibrosis…………………………………… | ☐ | ☐ | Any known syndrome…………………………….. | ☐ | ☐ |

| | | |
|---|---|---|
| Have you and/or your partner had carrier testing for cystic fibrosis?..………………………………. | ☐ | ☐ |
| Have you and/or your partner had carrier testing for Tay Sachs?..…………………………………. | ☐ | ☐ |
| Have you and/or your partner had testing for any other genetic disorders?................................. | ☐ | ☐ |

| | Yes | No |
|---|---|---|
| Are you or your partner adopted?…… | ☐ | ☐ |
| Are you and your partner related to each other – other than by marriage?…… | ☐ | ☐ |
| Have you ever had a pregnancy with growth restriction (IUGR)?…… | ☐ | ☐ |
| Have you ever had a baby born small for its age or delivered early because it was small?…… | ☐ | ☐ |
| Have you had genetic counseling with this pregnancy?…… | ☐ | ☐ |
| WITH A PREVIOUS PARTNER have you or your partner ever had a miscarriage, stillbirth or infant death?. | ☐ | ☐ |

If YES, how many?____________ How many weeks?____________________________________________

______________________________________________________________________________

| | Yes | No |
|---|---|---|
| Is there a history of infertility in you or your partner? …… | ☐ | ☐ |

If yes:

| | Yes | No |
|---|---|---|
| Was this pregnancy achieved with IVF?…… | ☐ | ☐ |
| Was an egg/sperm donor used?…… | ☐ | ☐ |

Did you use:

| | Yes | No |
|---|---|---|
| Intracytoplasmic sperm injection (ICSI) ?…… | ☐ | ☐ |
| Preimplantation genetic diagnosis (PGD)? | ☐ | ☐ |

| | Yes | No |
|---|---|---|
| Will you be 35 years of age or older at the time of delivery?…… | ☐ | ☐ |

Have you had:

| | Yes | No |
|---|---|---|
| First trimester screening…… | ☐ | ☐ |
| Integrated second trimester screening…… | ☐ | ☐ |

Date of blood draw____________________ Screening results: Positive ☐ Negative ☐ Don't know ☐

| | Yes | No |
|---|---|---|
| Free cell DNA prenatal testing…… | ☐ | ☐ |
| Prenatal diagnosis via chorionic villi sampling (CVS)…… | ☐ | ☐ |
| Prenatal diagnosis via amniocentesis…… | ☐ | ☐ |

**Please complete the following information:**

Medications (other than prenatal vitamins and iron) Please list___________________________________ ☐ ☐

| | Yes | No |
|---|---|---|
| Recreational drugs…… | ☐ | ☐ |
| Alcoholic drinks …… | ☐ | ☐ |
| Cigarette smoking…… | ☐ | ☐ |

| | Yes | No |
|---|---|---|
| Exposure to X-rays…… | ☐ | ☐ |
| Rashes, infectious diseases or fever…… | ☐ | ☐ |
| Spotting, bleeding or any other complication. | ☐ | ☐ |
| Diabetes or Lupus…… | ☐ | ☐ |

_____ I am interested in a consultation with a genetic counselor to discuss ethnicity/carrier screening and/or family health concerns.
_____ I am **NOT** interested in a consultation with a genetic counselor.

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

______________________________________________________________________________

Patient Signature Date