Center for Fetal Medicine and Women's Ultrasound

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Patient Information

Name	DOB	Occupation
Address	City	State & ZIP
Home Tel	Cell Tel	
Referring Physician		Tel
Partner Information: (If pregnant, then "partner" is the genetic / biological father of the pregnancy)		
Name	DOB	Occupation

The following questions will help your medical care team complete a medical and genetic risk assessment for you. 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 you 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 year	☐	☐
Spina 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? ☐ **Yes** ☐ **No**

Have you and/or your partner had carrier testing for Tay-Sachs? ☐ **Yes** ☐ **No**

Have you and/or your partner had testing for any other genetic disorders? ☐ **Yes** ☐ **No**

Are you or your partner adopted? ☐ **Yes** ☐ **No**

Are you and your partner related to each other – other than by marriage? ☐ **Yes** ☐ **No**

Have you ever had a pregnancy with growth restriction (IUGR)? ☐ **Yes** ☐ **No**

Have you ever had a baby born small for its age or delivered early because it was small? ☐ **Yes** ☐ **No**

Have you had genetic counseling with this pregnancy? ☐ **Yes** ☐ **No**

WITH A PREVIOUS PARTNER, have you or your partner ever had a miscarriage, ☐ **Yes** ☐ **No**

stillbirth or infant death? If YES, how many? _____ How many weeks? _____

Is there a history of infertility in you or your partner? ☐ **Yes** ☐ **No**

If YES:	**Yes**	**No**	**Did you use?**	**Yes**	**No**
Was this pregnancy achieved with IVF?	☐	☐	Intracytoplasmic sperm injection (ICSI)?	☐	☐
Was an egg / sperm donor used?	☐	☐	Pre-implantation genetic diagnosis (PGD)	☐	☐

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

Have you had:

First trimester screening? ☐ **Yes** ☐ **No**

Integrated second trimester screening ☐ **Yes** ☐ **No**

Date of blood draw _____ Screening results: ☐ **Positive** ☐ **Negative** ☐ **Don't know**

Free-cell DNA prenatal testing ☐ **Yes** ☐ **No**

Prenatal diagnosis via chorionic villus sampling (CVS) ☐ **Yes** ☐ **No**

Prenatal diagnosis via amniocentesis ☐ Yes ☐ No

Please complete the following information:

Medications (other than prenatal vitamins and iron: ☐ **Yes** ☐ **No**

Please list: _____

_____

	Yes	**No**		**Yes**	**No**
Recreational drugs	☐	☐	Exposure to x-rays	☐	☐
Alcoholic drinks	☐	☐	Rashes, infectious diseases or fever	☐	☐
Cigarette smoking	☐	☐	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** _____