

Pregnancy and Family History Questionnaire

Name: _____ **DOB:** _____ **Occupation:** _____

Preferred Contact Number: _____ **Referring Physician:** _____

Partner's Name: _____ **DOB:** _____ **Occupation:** _____

Please answer the following questions and provide an explanation when applicable. If you have any questions, then your genetic counselor will review the questionnaire with you.

Are you or your partner from any of these ethnic backgrounds? Please check all that apply.

- | | | | |
|---|---|---|--|
| <input type="checkbox"/> Caucasian | <input type="checkbox"/> African American | <input type="checkbox"/> Asian | <input type="checkbox"/> Hispanic |
| <input type="checkbox"/> Jewish | <input type="checkbox"/> African | <input type="checkbox"/> Asian Indian | <input type="checkbox"/> Central American |
| <input type="checkbox"/> Mediterranean (Greek, Italian, etc.) | <input type="checkbox"/> Caribbean | <input type="checkbox"/> Middle Eastern | <input type="checkbox"/> Cajun / French Canadian |
| <input type="checkbox"/> Other: _____ | | | |

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

	Yes	No		Yes	No
1. Down syndrome			8. Three or more pregnancy losses		
2. Other chromosome abnormality			9. Infant or childhood death		
3. Intellectual disability or autism			10. Stillborn		
4. Spina bifida (open spine)			11. Other inherited or genetic condition		
5. Heart defect at birth			12. Other serious medical condition or surgery		
6. Cleft lip/ Cleft palate			13. Any birth defect not listed above		
7. Blindness/ Deafness			14. Other:		

Please complete the following patient information pertaining to this current pregnancy.

- | | Yes | No |
|---|--------------------------|--------------------------|
| 1. Are you taking any medications?
Please List: _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Have you had exposure to alcohol, recreational drugs, cigarettes or X-rays? | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. Was an egg/sperm/embryo donor used to achieve this pregnancy? | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. Was IVF or IVF with ICSI used to achieve this pregnancy? Any PGS/PGD? | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. Have you had prenatal screening or NIPT (e.g. Panorama/MaterniT21/"nuchal" screen)? | <input type="checkbox"/> | <input type="checkbox"/> |
| 6. Have you or your partner had carrier testing for any genetic conditions in this pregnancy or a previous pregnancy (e.g. Cystic Fibrosis, Tay-Sachs disease, etc.)? | <input type="checkbox"/> | <input type="checkbox"/> |

What is your Due Date? _____

Patient Signature: _____ Date: _____

Reviewed by: _____ Date: _____