Prenatal Genetics Screen

Name_____ Date_____

(Please circle Yes or No Below)

1. Will you be 35 years or older when the baby is due? Yes No

2. Have you, the baby's father, or anyone in either of your families ever had any of the following disorders? Yes No
   - Downs Syndrome (mongolism) Yes No
   - Chromosomal Abnormality Yes No
   - Neural tube defect (spina bifida, anencephaly) Yes No
   - Hemophilia Yes No
   - Muscular Dystrophy Yes No
   - Cystic Fibrosis Yes No
   - Huntington's Chorea Yes No
   - If yes, please indicate the relationship of the affected person to you Yes No
     Or to the baby's father_____ Yes No

3. Did you or the baby's father have a birth defect? Yes No
   If yes, who has the defect and what is it? _____

4. In any previous pregnancies, have you or the baby's father had a child, born dead or alive, with a birth defect not listed in question 2? Yes No

5. Do you or the baby's father have any close relatives with developmental disabilities? Yes No

6. Do you, the baby's father, or a close relative in either of your families have a birth defect, familial disorder, or a chromosomal abnormality not listed above? Yes No

7. In any previous pregnancies, have you or the baby's father had a stillborn child, or three or more first trimester miscarriages? Yes No

8. Are you or the baby's father of Jewish ancestry? Yes No
   If yes, have either of you been tested for Tay-Sachs disease? Yes No

9. Are you or the baby's father African American? Yes No
   If yes, have either of you been tested for sickle cell trait? Yes No

10. Are you or the baby's father of Italian, Greek, or Mediterranean background? Yes No
    If yes, have either of you been tested for B-thalassemia? Yes No

11. Are you or the baby's father Philippine or Southwest Asian ancestry? Yes No
    If yes, have either of you been tested for a-thalassemia? Yes No

12. Excluding iron and vitamins, have you taken any medications or recreational drugs since being pregnant or since your last menstrual period? Yes No
    If yes, give the name of medication and the time taken during pregnancy: _____

Race (Please circle)
White/Caucasian Black/African American Hispanic Asian American Indian Other _____

_____ _____
Patient's Signature Patient's Name (printed)

_____ _____
Physician/Provider Signature Date