



**GENETIC FAMILY HISTORY & PREGNANCY QUESTIONNAIRE**

Date of Appointment \_\_\_\_\_

**Section 1. Patient Information**

Name \_\_\_\_\_ Date of Birth \_\_\_\_\_ Occupation \_\_\_\_\_  
 Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
 Home phone \_\_\_\_\_ Work phone \_\_\_\_\_ Cell phone \_\_\_\_\_  
 Referring Physician's Name \_\_\_\_\_ Referring Physician's Phone Number \_\_\_\_\_

**Section 2. Partner Information (If patient is pregnant, then "partner" is the 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.

**Section 3. Are you or your partner from any of these ethnic backgrounds?**

Please circle and check all that apply

	Patient	Partner
Chinese, Taiwanese, Asian Indian, Pakistani, Filipino, Pacific Islander or Southeast Asian . . . . .	<input type="checkbox"/>	<input type="checkbox"/>
Italian, Greek, Middle Eastern, Spanish or Portuguese . . . . .	<input type="checkbox"/>	<input type="checkbox"/>
Jewish, French Canadian or Cajun . . . . .	<input type="checkbox"/>	<input type="checkbox"/>
African American, African descent, Black, Puerto Rican, Caribbean or Central American. . . . .	<input type="checkbox"/>	<input type="checkbox"/>
Hispanic or Mexican . . . . .	<input type="checkbox"/>	<input type="checkbox"/>
Japanese or Korean. . . . .	<input type="checkbox"/>	<input type="checkbox"/>
Caucasian . . . . .	<input type="checkbox"/>	<input type="checkbox"/>
Other (specify) _____	<input type="checkbox"/>	<input type="checkbox"/>

**Section 4. Have you, your partner or anyone in your families ever had the following conditions:**

	Yes	No		Yes	No
Down syndrome . . . . .	<input type="checkbox"/>	<input type="checkbox"/>	polycystic kidney disease . . . . .	<input type="checkbox"/>	<input type="checkbox"/>
other chromosome problem . . . . .	<input type="checkbox"/>	<input type="checkbox"/>	Huntington disease . . . . .	<input type="checkbox"/>	<input type="checkbox"/>
mental retardation, autism, developmental delay. . . . .	<input type="checkbox"/>	<input type="checkbox"/>	heart defect at birth . . . . .	<input type="checkbox"/>	<input type="checkbox"/>
spina bifida (open spine). . . . .	<input type="checkbox"/>	<input type="checkbox"/>	cleft lip/cleft palate . . . . .	<input type="checkbox"/>	<input type="checkbox"/>
anencephaly (open head/brain). . . . .	<input type="checkbox"/>	<input type="checkbox"/>	blindness / deafness. . . . .	<input type="checkbox"/>	<input type="checkbox"/>
cystic fibrosis (a lung disease) . . . . .	<input type="checkbox"/>	<input type="checkbox"/>	blood disorder, such as hemophilia or sickle cell . . . . .	<input type="checkbox"/>	<input type="checkbox"/>
muscular dystrophy or neuromuscular disease . . . . .	<input type="checkbox"/>	<input type="checkbox"/>	stroke or blood clot at age less than 50. . . . .	<input type="checkbox"/>	<input type="checkbox"/>
skeletal disorder, like dwarfism . . . . .	<input type="checkbox"/>	<input type="checkbox"/>	any other birth defect/genetic/inherited condition . . . . .	<input type="checkbox"/>	<input type="checkbox"/>
neurofibromatosis . . . . .	<input type="checkbox"/>	<input type="checkbox"/>	any other serious medical condition or surgery . . . . .	<input type="checkbox"/>	<input type="checkbox"/>
Are you or your partner adopted? . . . . .	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>
Are you and your partner related to each other - other than by marriage? . . . . .	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>
Have you and/or your partner seen a specialist because of infertility? . . . . .	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>
Please specify the cause of infertility, if known. _____					
Have you and/or your partner had carrier testing for cystic fibrosis or any other genetic disorder? . . . . .	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>
Have you and/or your partner had blood chromosome testing? . . . . .	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>
Have you or your partner (with a previous partner) ever had a miscarriage, stillbirth or infant death? . . . . .	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>
If yes, how many times? _____ How many weeks/months along was/were the pregnancies? _____					
Have you ever had a pregnancy with growth restriction (IUGR)? . . . . .	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>
Have you ever had a baby born small for its age, or that the doctors delivered early because it was small? . . . . .	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>

**Section 5. Please complete the following patient information:**

	Yes	No		Yes	No
Are you currently pregnant? . . . . .	<input type="checkbox"/>	<input type="checkbox"/>	Since you have been pregnant:		
If yes, what is your due date? _____			have you taken any medication? . . . . .	<input type="checkbox"/>	<input type="checkbox"/>
If yes, was this pregnancy achieved with IVF? . . . . .	<input type="checkbox"/>	<input type="checkbox"/>	Please list: _____		
In this pregnancy, have you used or are you considering:			had any alcoholic drinks? . . . . .	<input type="checkbox"/>	<input type="checkbox"/>
donor egg (age of donor _____) or donor sperm? . . . . .	<input type="checkbox"/>	<input type="checkbox"/>	smoked any cigarettes? . . . . .	<input type="checkbox"/>	<input type="checkbox"/>
preimplantation genetic diagnosis/screening (PGD/PGS) . . . . .	<input type="checkbox"/>	<input type="checkbox"/>	used any recreational drugs? . . . . .	<input type="checkbox"/>	<input type="checkbox"/>
intracytoplasmic sperm injection (ICSI) . . . . .	<input type="checkbox"/>	<input type="checkbox"/>	had any rashes, infections, fevers? . . . . .	<input type="checkbox"/>	<input type="checkbox"/>
Do you have diabetes, PKU or lupus? . . . . .	<input type="checkbox"/>	<input type="checkbox"/>	had exposure to any x-rays (other than dental)? . . . . .	<input type="checkbox"/>	<input type="checkbox"/>
Have you had any of the following: maternal serum screening, AFP blood test, triple marker screen, quad screen, first trimester screen, sequential screen, integrated screen? . . . . .	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>
I have answered these questions to the best of my knowledge. _____					

Patient's signature \_\_\_\_\_ Date \_\_\_\_\_

FOR OFFICE USE ONLY

Reviewed by: \_\_\_\_\_ Date: \_\_\_\_\_