

ObGyn Associates of Chico Nurse-Midwifery Services, Inc.

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Genetic Questionnaire

Name: _____ Date: _____

Please answer the following questions to help us determine whether to recommend further testing.

Will you be age 35 or older when the baby is due? Yes No

Will the baby's father be 45 or older when the baby is due? Yes No

Have you or the baby's father had a previous child or close relative with any chromosomal abnormality? Yes No

Have you or the baby's father has a previous child or close relative with Down's syndrome? Yes No

Were you, the baby's father, any previous children, or close relatives born with a neural tube defect (spina bifida or anencephaly)? Yes No

Does any male relative in your family have:
Hemophillia? Yes No
Muscular Dystrophy? Yes No
Hydrocephalus (water on the brain)? Yes No

Do you or the baby's father have a birth defect, or have you or any close relative had a child born dead or alive with a birth defect not listed above? Yes No

Does any close relative on either side of the family have Cystic Fibrosis? Yes No

Are there other inherited or chromosomal disorders in the family? Yes No

Do you have any close family members whoa re developmentally disabled? Yes No

Are you and the baby's father first cousins or closely related? Yes No

Certain diseases are more common in certain ethnic groups...

Are you and the baby's father of African-American ancestry? Yes No
If yes, have you been tested for sickle cell trait? Yes No
What were the results? _____

Are you or the baby's father of Eastern European Jewish decent? Yes No
If yes, have you been tested to see if you are a carrier of Tay-Sachs or of Gaucher disease? Yes No
What were the results? _____

Are you of Asian Mediterranean (Greek, Italian, etc.) descent? Yes No
If yes, have you been tested for thalassemia trait? Yes No
What were the results? _____

Have you taken and medicines or drugs (prescription or not) during this pregnancy? Yes No
If so, what kind? _____

Have you taken any street drugs during this pregnancy? Yes No
If so, what kind? _____

Have you had chicken pox (varicella) or German measles (rubella)? Yes No

Are you interested in a genetic counselor? Yes No

PATIENT SIGNATURE: _____

REVIEWER SIGANTURE: _____