

PRENATAL GENETIC SCREEN

Name: _____

Date: _____

1. Will you be 35 years or older when the baby is due? Yes _____ No _____
2. Have you, the baby's father, or either of your families ever had any of the following disorders:
 - a. Down's Syndrome (Mongolism) Yes _____ No _____
 - b. Other chromosomal abnormalities Yes _____ No _____
 - c. Neural tube defect, ie Spina Bifida (meningomyelocele or open spine), anencephaly Yes _____ No _____
 - d. Hemophilia Yes _____ No _____
 - e. Muscular dystrophy Yes _____ No _____
 - f. Cystic fibrosis Yes _____ No _____
 - g. Other Yes _____ No _____If yes, indicate the relationship of the affected person to you or the baby's father _____
3. Do 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 deceased or alive with a birth defect not listed in question 2? Yes _____ No _____
If yes, who has the defect and what is it? _____
5. Do you or the baby's father or a close relative have mental retardation? Yes _____ No _____
6. In any previous pregnancies, have you or the baby's father had a stillborn child or three or more first-trimester spontaneous pregnancy losses? Yes _____ No _____
If yes, have either of you had a chromosomal study? Yes _____ No _____
Indicate who and the results if yes _____
7. Are you or the baby's father of Jewish ancestry, Cajun or French-Canadian? Yes _____ No _____
If yes, have either of you been screened for Tay-Sachs diseases? Yes _____ No _____
Indicate person and results if yes _____
8. Are you or the baby's father African American? Yes _____ No _____
If yes, have either of you been screened for sickle cell trait? Yes _____ No _____
Indicate person and results if yes _____
9. 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 _____
Indicate person and results if yes _____
10. Are you or the baby's father of Philippine or Southeast Asian ancestry? Yes _____ No _____
If yes, have either of you been tested for A-thalassemia? Yes _____ No _____
Indicate person and results if yes _____

ENVIRONMENTAL FACTORS

Do You:

- | | | | |
|------------------------------------|--------------------|--|--------------------|
| Drink caffeinated drinks? | Yes _____ No _____ | Operate heavy or vibrating equipment? | Yes _____ No _____ |
| Use artificial sweeteners? | Yes _____ No _____ | Work with radiation? | Yes _____ No _____ |
| Cigarette use prior to pregnancy? | Yes _____ No _____ | Have exposure to extreme heat? | Yes _____ No _____ |
| Cigarette use currently? | Yes _____ No _____ | Handle chemicals, dyes or gases? | Yes _____ No _____ |
| Drink alcohol prior to pregnancy? | Yes _____ No _____ | Have help at home? | Yes _____ No _____ |
| Drink alcohol currently? | Yes _____ No _____ | Have 2 or more pre-school children? | Yes _____ No _____ |
| Previously or currently use drugs? | Yes _____ No _____ | Exercise 15 minutes or more 3 x week? | Yes _____ No _____ |
| Have cats in your home? | Yes _____ No _____ | Use a jacuzzi or sauna? | Yes _____ No _____ |
| Eat raw meats or fish? | Yes _____ No _____ | Have excessive standing, lifting,
climbing stairs or traveling? | Yes _____ No _____ |
| Routinely perm your hair? | Yes _____ No _____ | Comments _____ | |
| Work outside the home? | Yes _____ No _____ | | |
| Swing or rotate shifts? | Yes _____ No _____ | | |