



Prenatal Questionnaire

Patient's Name: _____ First day of last Menstrual period: ____/____/____

Physician's Name: _____

The following questions will help in the care of your pregnancy. Your answers may indicate whether certain tests would be appropriate in helping to evaluate the health of your unborn baby. The following is a screening questionnaire only. For any further concerns, please contact your doctor.

- | | | |
|---|-----|----|
| 1. Will you be age 35 or older when the baby is due? | Yes | No |
| 2. Have you or the baby's father had a previous child? | Yes | No |
| 3. Do you or the baby's father have a sibling with Down Syndrome | Yes | No |
| 4. Were you, the baby's father, any previous children, or any close relatives born with a neural tube defect (such as spinal bifida or anencephaly)? | Yes | No |
| 5. Does any male relative in your family have: | | |
| a. Hemophilia? | Yes | No |
| b. Muscular Dystrophy? | Yes | No |
| c. Hydrocephalus (water on the brain)? | Yes | No |
| 6. Do you or the baby's father have a birth defect, or have you had a child born dead or alive with a birth defect not listed in the above questions? | Yes | No |
| 7. Does any close relative on either side of the family have Cystic Fibrosis? | Yes | No |
| 8. Are there other known inherited or chromosomal disorders in the family? | Yes | No |
| 9. Do you have one or more close family members who are mentally retarded? | Yes | No |
| 10. Are you and the baby's father first cousins or more closely related? | Yes | No |

11. Certain genetic diseases are more common in certain ethnic groups than others.

a. Are you of Black ancestry?

Yes No

If yes, have you been tested for the Sickle Cell Trait?

Yes No

If so, what were the results?

b. Are you of eastern European Jewish descent?

Yes No

If yes, have you been tested to whether you are a Tay-Sachs carrier?

Yes No

What were the results?

c. Are you of Asian or Mediterranean (Greek, Italian, ect.) descent?

Yes No

If yes, have you been tested for Thalassemia trait?

Yes No

What were the results?

12. Have you taken any medications or drugs (prescription or not) during this pregnancy?

Yes No

If so, what kind?

13. Do you smoke and/or drink alcoholic beverages?

Yes No