

South Shore/Hanover Obstetrics and Gynecology, Inc.

21 School Street
Quincy, MA 02169
617.472.5940

135 Webster Street
Hanover, MA 02339
781.878.7020

Albert H. Marcus, MD
Gerald J. Pouliot, MD
Paul W. Keogh, MD
Brian P. Sullivan, MD
Brigid K. McCue, MD
Johanna Poulin, MD

Prenatal Genetic Screening Questionnaire

Patient's Name: _____ **Date of Birth:** ____/____/____

Doctor / Clinic: _____ **Today's Date:** ____/____/____

The following questionnaire will help evaluate the health of your unborn baby. Your answers may indicate that certain tests would be appropriate. Please answer all questions as completely as possible. All information will be kept to a minimum.

1. Will you be age 35 or older at your due date? Yes No Your due date is ____/____/____

2. Are you OR the baby's father from any of these ethnic backgrounds? Southern Chinese, Asian Indian, Taiwanese, Filipino or Southeast Asian Italian, Greek, Middle Eastern, or Spanish

If yes, have you or the baby's father been tested to see if you are a carrier of thalassemia or other hemoglobin abnormality? Yes No Don't Know

If yes, who was tested and what were the results?

3. Have you, the baby's father, or any relative had a neural tube defect, (such as open spine, spina bifida, anencephaly)? Yes No Don't Know

If yes, please write the diagnosis or describe the defect. How is this person related to you or the baby's father?

4. Have you, the baby's father, or anyone in your families been born with a heart defect? Yes No Don't Know

If yes, please write the diagnosis or describe the defect. How is this person related to you or the baby's father?

5. Have you, the baby's father, or anyone in your families had a pregnancy or a child diagnosed with Down Syndrome? Yes No Don't Know

If yes, how is this person related to you or the baby's father?

6. Are you or the baby's father Jewish or French Canadian?

- Yes
- No
- Don't Know

If yes, have either you or the baby's father been tested to see if you are carrier's of Tay-Sachs disease, cystic fibrosis, or Canavan Disease?

- Yes
- No
- Don't Know

If yes, who was tested and what were the results?

7. Are you or the baby's father African American or of African descent?

- Yes
- No

If yes, have either you or the baby's father been tested to see if you have sickle cell trait (are a carrier of sickle cell anemia)?

- Yes
- No
- Don't Know

If yes, who was tested and what were the results?

8. Do you, the baby's father, or anyone in your families have hemophilia or another bleeding disorder?

- Yes
- No
- Don't Know

If yes, please write the diagnosis or describe the disorder. How is this person related to you or the baby's father?

9. Do you, the baby's father, or anyone in your families have a neuromuscular disease or muscular dystrophy?

- Yes
- No
- Don't Know

If yes, please write the diagnosis or describe the disease. How is this person related to you or the baby's father?

10. Do you, the baby's father, or anyone in your families have cystic fibrosis?

- Yes
- No
- Don't Know

If yes, how is this person related to you or the baby's father?

11. Do you, the baby's father, or anyone in your families have Huntington's disease?

- Yes
- No
- Don't Know

If yes, how is this person related to you or the baby's father?

12. Do you, the baby's father, or anyone in your families have autism or mental retardation?

- Yes
- No
- Don't Know

If yes, please write the diagnosis or or describe the problem. How is this person related to you or the baby's father?

13. Do you, the baby's father, or anyone in your families have an inherited disorder or chromosome abnormality not listed above? Yes No Don't Know

If yes, please write the diagnosis or describe the problem. How is this person related to you or the baby's father?

14. Do you have insulin dependent diabetes, PKU, lupus, or another chronic condition? Yes No Don't Know

If yes, please write the diagnosis.

15. Do you, the baby's father, or anyone in your families have a birth defect not listed above? Yes No Don't Know

If yes, please write the diagnosis or describe the defect. How is this person related to you or the baby's father?

16. Have you or your baby's father had a stillborn child or two or more pregnancy losses in this or any other relationship? Yes No Don't Know

If yes, please describe:

17. Have you taken any medications, recreational drugs, or had any alcoholic drinks since your last menstrual period, or had any rashes or infectious diseases? Yes No Don't Know

If yes, please describe:

18. Did you, the baby's father or anyone in your families have any other serious medical condition in infancy or childhood? Yes No Don't Remember

If yes, please describe. How is this person is related to you or the baby's father?

I have answered these questions to the best of my knowledge _____ *Patient Signature*

For office use only: Reviewed by: _____ **Date:** ____/____/____