**GENETIC SCREENING AND PREGNANCY QUESTIONNAIRE**

Name: ___________________________________________ DOB: ___________ Age: ________

Pregnancy History:

<table>
<thead>
<tr>
<th># of Pregnancies</th>
<th>Full Term Deliveries</th>
<th>Preterm Deliveries</th>
<th>Induced AB</th>
<th>Miscarriages</th>
<th>Ectopic</th>
<th>Multiples</th>
<th>Living</th>
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**Past Pregnancy Details:**

<table>
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<tr>
<th>Date mm/dd/yy</th>
<th>Weeks along</th>
<th>Hours in labor</th>
<th>Birth Wt.</th>
<th>Sex M/F</th>
<th>Type of Delivery</th>
<th>Anesthesia</th>
<th>Early Labor?</th>
<th>Complications</th>
<th>Hospital</th>
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<td></td>
<td>(C-sect, Vaginal, VBAC, Forceps, Vacuum)</td>
<td>(Epidural, General Spinal, IV, None)</td>
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Genetic Screening Questions:

Please identify relationship to child: Mother, Father, Brother, Sister

Maternal or Paternal: Grandmother, Grandfather, Aunt, Uncle

________ Patient age 35 years or older as of date of delivery

________ Genetic Carrier Status

________ Anencephalus (neural tube defect)

________ Autistic Disorder

________ Canavan Disease (Ashkenazi Jewish)

________ Child with Birth Defects not listed

________ Chromosomal Anomaly Syndrome

________ Congenital Heart Defects

________ Cystic Fibrosis

________ Down Syndrome

________ Familial Dysautonomia (Ashkenazi Jewish)

________ Family History of Blood Disorders

________ Family History of Mental Retardation

________ Fragile X Syndrome

________ Genetic or Familial Dysautonomia (Ashkenazi Jewish)

________ Other not Listed

________ Jewish Ancestry

Genetic Screening Questions:

Medications: Give medication name, dose & schedule. Include vitamins, herbals, laxatives and over the counter medications taken since last menstrual period.

Infection Risks:

_____ Exposure to: Chlamydia Genital Herpes Gonorrhea Hepatitis B HIV Syphilis TB

_____ High Risk for: Genital Herpes Hepatitis B HIV TB

_____ Possible Exposure to: Genital Herpes Hepatitis B HIV STD

_____ Personal History of MRSA

_____ History of Blood Transfusion(s) _____ Infection risk/immunosuppression _____ Rash/viral illness since LMP

_____ History of Chicken Pox _____ Multiple Sexual Partners _____ Risk for Toxoplasmosis

_____ History of STD’s _____ New Sexual Partners _____ No known infection risk

Are there cats in your home? ______________

Patient Signature: ___________________________ Date: __________

Rev. 1/2012