Reset Form

Print Form

Womens Health Partners, LLC

GENETIC QUESTIONNAIRE

Name: _____

	Yes	No	
1) Will you be age 35 or older when your baby is due?	☐	☐	
2) Have you or your baby's father, or anyone in either of your family had:	Yes	No	
a) Down Syndrome (mongolism)?	☐	☐	
b) Spina Bifida or Anencephaly (open spine/ open brain)?	☐	☐	
c) Cystic Fibrosis?	☐	☐	
d) Bleeding disorder?	☐	☐	
d) Muscle disorder?	☐	☐	
e) Other birth defects?	☐	☐	
If yes, list type & exact relationship of affected individual(s):	☐	☐	
3) Do you or your baby's father have any relatives who are intellectually disabled?	Yes	No	
	☐	☐	
If yes, list cause (if known) and exact relationship of affected individual (s):			
4) Do you or your baby's father have a genetic disease or chromosomal disorder not listed above?	Yes	No	
	☐	☐	
If yes, list cause (if known) and exact relationship of affected individual (s):			
5) Do you or your baby's father have any blood relatives with any genetic (inherited) disorders?	Yes	No	
	☐	☐	
If yes, list cause (if known) and exact relationship of affected individual (s):			
6) Have you, or anyone your baby's father impregnated, had two or more spontaneous pregnancy losses?	Yes	No	
	☐	☐	
7) Are you and your baby's father blood relatives?	Yes	No	
	☐	☐	
If yes, what is the exact relationship?			
8) Are you and your baby's father of Jewish ancestry?	Yes	No	
	☐	☐	
If yes, have either of you been screened for Tay-Sachs, Canavan or cystic fibrosis?	☐	☐	
If yes, indicate who was screened and results:			
9) Are you and your baby's father of black ancestry?	Yes	No	
	☐	☐	
If yes, have either of you been screened for Sickle Cell disease?	☐	☐	
If yes, indicate who was screend and results:			
10) What is your ethnic background? (Where was your family born before coming to the United States?			
11) What is the ethnic background of your baby's father? (Where was his family born before coming to the United States)?			
12) Are you or your baby's father exposed to any chemical on a daily basis?	Yes	No	
	☐	☐	
if yes, what chemicals and under what circumstances			

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Yes No

13) Have you taken any medications during this pregnancy? ☐ ☐

If so, list medications, dosages, dates and reason

	Medication	Dosage	Frequency	Reason
1.				
2.				
3.				
4.				

Yes No

14) Were you using birth control when you became pregnant? ☐ ☐ _____

If yes, what type? _____

Yes No

15) Have you or the baby's father had any x-rays within three months prior to the start of this pregnancy? if yes, list part of the body and date and if a shield was used. ☐ ☐

	Part of Body	Date	Number of Films	Shield Used
1.				
2.				
3.				

Yes No

16) Do you smoke? ☐ ☐ _____

If yes, how many cigarettes per days? _____

Yes No

17) Do you drink alcohol? ☐ ☐ _____

If yes, how many drinks per day / week? _____

Yes No

18) Do you use any ilicit drugs? ☐ ☐ _____

If yes, what types? _____

19) List any concerns you have regarding this pregnancy?

_____

_____

_____

_____

_____

Yes No

20) Are you interested in genetic testing even if you have no risk factors? ☐ ☐ _____

Name: _____

Address: _____ City: _____ State Florida

Birthday: _____ Phone Number _____ Zip Code: _____

Signature: _____