WINCHESTER OB-GYN ASSOCIATES, P.C.

Prenatal Genetic Questionnaire

In order to provide you with optimal prenatal care, we ask that you complete the following health questionnaire. The questions will apply to you, your family, the baby's father, and the family of the baby's father. If you do not understand any of the questions, please ask for assistance during your first prenatal appointment. This information will remain confidential. Thank you.

TODAY'S DATE:_____

PATIENT NAME:_____ DOB:_____

OCCUPATION:_____

NAME OF BABY'S FATHER:_____ DOB:_____

OCCUPATION:_____

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1. When was your last menstrual period? _____

2. How old will you be when the baby is due? _____

3. How old will the baby's father be when the baby is due? _____

4. Have you ever been pregnant before? ☐ YES ☐ NO
   If yes, please list any problems or complications:_____
   _____

5. How many living children do you have? _____

6. Have you (or the baby's father in any previous relationship) had two or more spontaneous pregnancy losses (miscarriages) or a stillbirth? ☐ YES ☐ NO
   If yes, please explain:_____
   _____

7. Have you, the baby's father, or anyone in the family ever had: (*please check any that apply*)

   ☐ Cystic Fibrosis ☐ Hemophilia ☐ Anencephaly *(part of the brain that did not develop)*
   ☐ Cerebral Palsy ☐ Down's Syndrome ☐ Hydrocephaly *(water on the brain)*
   ☐ Cleft lip/Cleft Palate ☐ Fragile X Syndrome ☐ Mental Retardation
   ☐ Club Foot ☐ Spina Bifida ☐ Muscular Dystrophy

   If yes, please explain:_____
   _____

8. Have you, the baby's father or any relative ever had a birth defect, chromosomal abnormality or inherited health problem not listed above? ☐ YES ☐ NO
   If yes, please explain:_____
   _____

9. Have you, or any female relative, ever had an amniocentesis? ☐ YES ☐ NO
If yes, please explain:_____

_____

10. Are you or the baby's father of Jewish or French Canadian ancestry? ☐ YES ☐ NO

If yes, have either of you ever been screened for Tay-Sach's disorder? ☐ YES ☐ NO
Please indicate results:_____

_____

11. Are you or the baby's father Black? ☐ YES ☐ NO

If yes, have either of your ever been screened for Sickle Cell Trait? ☐ YES ☐ NO
Please indicate results:_____

_____

12. Are you or the baby's father of Italian, Greek, Mediterranean, Southeast Asian or Philippine decent? ☐ YES ☐ NO

If yes, have either of you ever been screened for Thalessemia? ☐ YES ☐ NO
Please indicate results:_____

_____

13. Are you and the baby's father related, or do you have relatives in common? ☐ YES ☐ NO

14. Do you have any of the following medical conditions? (*please check any that apply)*
☐ Diabetes Mellitus ☐ Epilepsy ☐ Lupus ☐ Hypertension

If yes, please explain:_____

_____

15. Since your last menstrual period, have you been exposed to any of the following infectious diseases? (*please check any that apply*)
☐ Chicken Pox ☐ Measles ☐ Hepatitis ☐ Tuberculosis ☐ Fifth's Disease

☐ Other:_____

If yes, please explain:_____

_____

16. Have you or the father of the baby ever been exposed to or tested positive for HIV (AIDS)? ☐ YES ☐ NO

If yes, please explain:_____

17. Do you drink alcohol? ☐ YES ☐ NO

18. Do you smoke cigarettes? ☐ YES ☐ NO

19. Have you taken ANY prescribed or over the counter medications since your last menstrual period? ☐ YES ☐ NO
If yes, please list medication, dosage and when taken:_____

_____

_____

_____

20. Have you taken or used recreational or street drugs since your last menstrual period? ☐ YES ☐ NO

If yes, please list type of drug and when taken: _____

_____

21. Have you had an X-ray since your last menstrual period? ☐ YES ☐ NO

If yes, please list type of X-ray and date: _____

_____

22. Have you had any chemical or radiation exposure since your last menstrual period? ☐ YES ☐ NO

If yes, please explain: _____

_____

23. Do you own a cat that uses an indoor litter box? ☐ YES ☐ NO

24. Do you do any gardening? ☐ YES ☐ NO

25. Do you have any major concerns about this pregnancy, your health, or family history that have not already been addressed? ☐ YES ☐ NO

If yes, please explain: _____

_____

_____

_____

_____

_____ _____

Signature of Patient *Date*