

# CELEBRATION OF LIFE SPONSORSHIP PROGRAM

## PRECONCEPTION GENETIC SCREENING QUESTIONNAIRE

Patient's Name: \_\_\_\_\_ DOB: \_\_\_\_\_

Partner's Name: \_\_\_\_\_ DOB: \_\_\_\_\_

Doctor/Clinic: \_\_\_\_\_ Today's Date: \_\_\_\_\_

In the event you become pregnant while in our Program, the following questionnaire will help evaluate the potential risks for 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 confidential.

				<b><u>ORDERS</u></b>
1. Are you 35 or older?	<input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> N/A, if male	Your due date is ___/___/___	____ CVS ____ Amnio ____ AFP, hCG, UE3
2. Are you OR your partner from any of these ethnic backgrounds?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Southern Chinese, Asian Indian, Taiwanese, Filipino or Southeast Asian  Italian, Greek, Middle Eastern or Spanish	If yes, have you or your partner been tested to see if you are a carrier of thalassemia or other hemoglobin abnormality? <input type="checkbox"/> Yes <input type="checkbox"/> Don't know If yes, who was tested and what were the results? _____	____ CBC and  HgbElectrophoresis
3. Have you or your partner or any relative had a neural tube defect (such as open spine, spina bifida, anencephaly)?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	If yes, please write the diagnosis or describe the defect. How is this person related to you or the baby's father? _____	____ Folic Acid 4 mg
4. Have you or your partner or anyone in your families been born with a heart defect?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	If yes, please write the diagnosis or describe the defect. How is this person related to you or your partner? _____	____ Fetal  Echocardiogram 18-20 weeks
5. Have you or your partner or anyone in your families had a pregnancy or a child diagnosed with Down syndrome?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	If yes, how is this person related to you or your partner? _____	____ CVS ____ Amnio ____ AFP, hCG, UE3
6. Are you or your partner Jewish?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	If yes or don't know, have either you or your partner been tested to see if you are carriers of Tay-Sachs disease, cystic fibrosis, or Canavan disease,? <input type="checkbox"/> Yes <input type="checkbox"/> Don't know If yes, who was tested and what were the results? _____	If no, check for: ____ AshKenazi Jewish Carrier Testing and Gaucher Disease
7. Are you or your partner French Canadian?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	If yes or don't know, have either you or your partner been tested to see if you are carriers of Tay-Sachs disease? <input type="checkbox"/> Yes <input type="checkbox"/> Don't know If yes, who was tested and what were the results? _____	If no, check for: ____ Tay-Sachs
8. Are you or your partner African American or of African descent?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	If yes or don't know, have either you or your partner been tested to see if you have sickle cell trait (are a carrier of sickle cell anemia or Thalassemia)? <input type="checkbox"/> Yes <input type="checkbox"/> Don't know If yes, who was tested and what were the results? _____  If no, check for: _____	____ CBC and  HgbElectrophoresis

				<b><u>ORDERS</u></b>
9. Do you or your partner or anyone in your families have hemophilia or another bleeding disorder?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	If yes, please write the diagnosis or describe the disorder. How is this person related to you or your partner? _____	____ Preconception Genetic Counseling
10. Do you or your partner or anyone in your families have a neuromuscular disease or muscular dystrophy?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	If yes, please write the diagnosis or describe the disease. How is this person related to you or your partner? _____	____ Preconception Genetic Counseling
11. Do you or your partner or anyone in your families have cystic fibrosis?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	If yes, how is this person related to you or your partner? _____	____ CF Screen
12. Do you or your partner or anyone in your families have Huntington's disease?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	If yes, how is this person related to you or your partner? _____	____ Preconception Genetic Counseling
13. Do you or your partner or anyone in your families have autism or mental retardation?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	If yes, please write the diagnosis or describe the problem. How is this person related to you or your partner? _____	____ Preconception Genetic Counseling (FragileX, inherited chromosome rearrangement)
14. Do you or your partner or anyone in your families have an inherited disorder or chromosome abnormality not listed above?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	If yes, please write the diagnosis or describe the problem. How is this person related to you or your partner? _____	____ Preconception Genetic Counseling
15. Do you or your partner have insulin dependent diabetes, PKU, lupus, or another chronic condition?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	If yes, please write the diagnosis : _____	____ Preconception Genetic Counseling
16. Do you or your partner or anyone in your families have a birth defect not listed above?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	If yes, please write the diagnosis or describe the defect. How is this person related to you or your partner? _____	____ Preconception Genetic Counseling
17. Have you or your partner had a stillborn child or two or more pregnancy losses in this or any other relationship?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	If yes, please describe: _____	____ POC ____ Chromosomes ____ Peripheral Blood Chromosomes ____ CVS or Amnio
18. Have you or your partner taken any medications, recreational drugs, or had any alcoholic drinks since your last menstrual period, or had any rashes or infectious diseases?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	If yes, please describe: _____	____ Counseling re: Teratogenic Exposure ____ CVS or Amnio
19. Did you or your partner or anyone in your families have any other serious medical condition in infancy or childhood?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	If yes, please describe. How is this person related to you or your partner? _____	____ Preconception Genetic Counseling

I have answered these questions to the best of my knowledge.

\_\_\_\_\_  
Patient Signature

For office use only: Reviewed by: \_\_\_\_\_ Date: \_\_\_\_\_