Patient Name/I.D. Number _____ Physician Name _____

## Family History & Genetic Screening

(to be filled out by patient)

1. Have either you or the baby's father had a child born with a birth defects? ❑ Yes ❑ No

   If yes, please describe: _____

2. Did either you or the baby's father have a birth defect yourselves? ❑ Yes ❑ No

   If yes, please describe: _____

3. Please describe any abnormalities that have occurred in children in your family or the baby's father's family (for example, Down's syndrome or other chromosomal defect, mental retardation, emotional problems, birth defects, deformities,or inherited diseases like hemophilia, muscular dystrophy, or cystic fibrosis).

   _____

   How is the affected person related to you? _____

4. Do either you or the baby's father have a history of pregnancy losses (miscarriages or stillborn)? ❑ Yes ❑ No
   If yes, have either of you had genetic counseling? ❑ Yes ❑ No
   If yes, have either of you had chromosomal studies? ❑ Yes ❑ No

   Where and results: _____

5. Some genetic problems may occur more frequently in couples with certain racial or ancestral backgrounds. Please check if either you or the baby's father is one of these backgrounds:

   Jewish ancestry? ❑ Yes ❑ No
   If yes, have you had Tay Sachs screening tests? ❑ Yes ❑ No
   Date: _____ Result: _____

   Black? ❑ Yes ❑ No
   If yes, have you had Sickle Cell screening? ❑ Yes ❑ No
   Date: _____ Result: _____

   Italian, Greek, or Mediterranean? ❑ Yes ❑ No
   If yes, have you been tested for Beta-thalassemia? ❑ Yes ❑ No
   Date: _____ Result: _____

   Phillipine or Southeast Asian? ❑ Yes ❑ No
   If yes, have you been tested for Alpha-thalassemia? ❑ Yes ❑ No
   Date: _____ Result: _____

6. Please indicate if anyone in your family or the baby's father's family has: ❑ Asthma ❑ Bleeding disorder ❑ Diabetes

   If yes, how is that person related to you? _____

7. Please list any concerns you have about birth defects or inherited disorders:

   _____

   _____

8. Will you be 35 or older at the time the baby is born? ❑ Yes ❑ No

9. Is there a family history of allergies or heart disease (including high blood pressure)? ❑ Yes ❑ No

Patient Signature _____ Print Name _____ Date _____

***Please complete Obstetrical Medical History on opposite side.***

Physician Notes on Genetic Screen: _____

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