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PRENATAL GENETIC SCREENING QUESTIONNAIRE

Patient Name _____ Date _____

1. Have you, the baby's father, or anyone in either of your families ever had any of the following disorders?

- | | | | |
|----|--|-----|----|
| a. | Down syndrome?----- | YES | NO |
| b. | Other chromosomal abnormality?----- | YES | NO |
| c. | Neural tube defect (spina bifida, anencephaly) | YES | NO |
| d. | Hemophilia?----- | YES | NO |
| e. | Muscular dystrophy?----- | YES | NO |
| f. | Cystic fibrosis?----- | YES | NO |

If you answered yes to any of the above, indicate the relationship of the affected person to you or the baby's father _____

2. Do you or the baby's father have a birth defect?----- YES NO

If yes, who has the defect and what type is it? _____

3. Have you or the baby's father had a child born alive or dead with a birth defect not listed in #1 above? YES NO

If yes, who had the defect and what type is it? _____

4. Do you or the baby's father have any close relatives with mental retardation? YES NO

If so, indicated the relationship of the affected person to you or the baby's father and the cause, if known. _____

Have you or the baby's father been tested for Fragile X? _____

5. Do you, the baby's father or a close relative in either family have a birth defect, familial disorder, or other chromosomal abnormality not listed above? YES NO

If yes, indicate the relationship of the affected person and the condition _____
