



GENETIC QUESTIONNAIRE

PATIENT NAME: _____

PHYSICIAN: _____

DATE: _____

ACCOUNT: _____

These questions will help in the care of your pregnancy. Your answers may indicate whether certain tests would be helpful in evaluating the health of your unborn baby. Have you, the father of the baby, or anyone in either of your families ever had any of the following? Please specify for each "yes" (✓) answer, the problem and the relationship of the affected person to you or the baby's father.

YES	NO	FACTOR	EXPLANATION	RELATIONSHIP
		Will you be 25 years or older when the baby is due?		
		Mental retardation		<input type="checkbox"/> Yourself <input type="checkbox"/> Baby's Father <input type="checkbox"/> Your: <input type="checkbox"/> Baby's Father's:
		Down Syndrome or any other chromosome abnormality		<input type="checkbox"/> Yourself <input type="checkbox"/> Baby's Father <input type="checkbox"/> Your: <input type="checkbox"/> Baby's Father's:
		Birth defects (i.e., cleft lip or palate, limb defects)		<input type="checkbox"/> Yourself <input type="checkbox"/> Baby's Father <input type="checkbox"/> Your: <input type="checkbox"/> Baby's Father's:
		Spina Bifida (open spine), anencephaly, neural tube defect		<input type="checkbox"/> Yourself <input type="checkbox"/> Baby's Father <input type="checkbox"/> Your: <input type="checkbox"/> Baby's Father's:
		Hydrocephalus (water on the brain)		<input type="checkbox"/> Yourself <input type="checkbox"/> Baby's Father <input type="checkbox"/> Your: <input type="checkbox"/> Baby's Father's:
		Congenital blindness or deafness		<input type="checkbox"/> Yourself <input type="checkbox"/> Baby's Father <input type="checkbox"/> Your: <input type="checkbox"/> Baby's Father's:
		Blood disorders (anemia)		<input type="checkbox"/> Yourself <input type="checkbox"/> Baby's Father <input type="checkbox"/> Your: <input type="checkbox"/> Baby's Father's:
		Cystic Fibrosis		<input type="checkbox"/> Yourself <input type="checkbox"/> Baby's Father <input type="checkbox"/> Your: <input type="checkbox"/> Baby's Father's:
		Epilepsy or seizures		<input type="checkbox"/> Yourself <input type="checkbox"/> Baby's Father <input type="checkbox"/> Your: <input type="checkbox"/> Baby's Father's:
		Heart defects		<input type="checkbox"/> Yourself <input type="checkbox"/> Baby's Father <input type="checkbox"/> Your: <input type="checkbox"/> Baby's Father's:
		Hemophilia (bleeding)		<input type="checkbox"/> Yourself <input type="checkbox"/> Baby's Father <input type="checkbox"/> Your: <input type="checkbox"/> Baby's Father's:
		Huntington's Chorea		<input type="checkbox"/> Yourself <input type="checkbox"/> Baby's Father <input type="checkbox"/> Your: <input type="checkbox"/> Baby's Father's:
		Kidney problems		<input type="checkbox"/> Yourself <input type="checkbox"/> Baby's Father <input type="checkbox"/> Your: <input type="checkbox"/> Baby's Father's:
		Mental illness (schizophrenia or manic depression)		<input type="checkbox"/> Yourself <input type="checkbox"/> Baby's Father <input type="checkbox"/> Your: <input type="checkbox"/> Baby's Father's:
		Muscular Dystrophy		<input type="checkbox"/> Yourself <input type="checkbox"/> Baby's Father <input type="checkbox"/> Your: <input type="checkbox"/> Baby's Father's:
		Neurofibromatosis		<input type="checkbox"/> Yourself <input type="checkbox"/> Baby's Father <input type="checkbox"/> Your: <input type="checkbox"/> Baby's Father's:
		Stillbirth		<input type="checkbox"/> Yourself <input type="checkbox"/> Baby's Father <input type="checkbox"/> Your: <input type="checkbox"/> Baby's Father's:
		3 or more miscarriages		<input type="checkbox"/> Yourself <input type="checkbox"/> Baby's Father <input type="checkbox"/> Your: <input type="checkbox"/> Baby's Father's:
		Birth defects or inherited disorders not listed above		<input type="checkbox"/> Yourself <input type="checkbox"/> Baby's Father <input type="checkbox"/> Your: <input type="checkbox"/> Baby's Father's: