



- Oakland Genetics (510) 752-6298
- Sacramento Genetics (916) 614-4075
- San Francisco Genetics (415) 833-2998
- San Jose Genetics (408) 972-3300
- Fresno Genetics (559) 324-5330

MR#: _____

Name: _____

PRENATAL GENETIC QUESTIONNAIRE

DATE	LAST MENSTRUAL PERIOD
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IMPRINT AREA

Have **you**, the **father of your baby**, or **any close family members** (for example: children, parents, sisters/brothers, aunts/uncles, nieces/nephews) ever had the following: (Please describe their relationship to you and any known details.)

	YES	NO	<u>RELATIONSHIP TO PATIENT/DETAILS</u>
Chromosome problem (like Down Syndrome)	<input type="checkbox"/>	<input type="checkbox"/>	
Mental retardation	<input type="checkbox"/>	<input type="checkbox"/>	
Spina bifida (open spine)	<input type="checkbox"/>	<input type="checkbox"/>	
Anencephaly (opening in head/brain)	<input type="checkbox"/>	<input type="checkbox"/>	
Bleeding disorder (like hemophilia)	<input type="checkbox"/>	<input type="checkbox"/>	
Cystic fibrosis (a lung disease)	<input type="checkbox"/>	<input type="checkbox"/>	
Muscular dystrophy/other muscle, nerve disorder (not multiple sclerosis)	<input type="checkbox"/>	<input type="checkbox"/>	
Tay-Sachs or Canavan disease	<input type="checkbox"/>	<input type="checkbox"/>	
Sickle cell or Thalassemia	<input type="checkbox"/>	<input type="checkbox"/>	
Heart defect at birth (requiring surgery/treatment)	<input type="checkbox"/>	<input type="checkbox"/>	
Any birth defect not listed above	<input type="checkbox"/>	<input type="checkbox"/>	
Any other inherited (genetic) condition	<input type="checkbox"/>	<input type="checkbox"/>	

1. Have you or the baby's father had 3 or more miscarriages or a baby who died at birth/early infancy? . . Yes No
2. Have you taken any of the following during your pregnancy:

<input type="checkbox"/> Anti-cancer medications	<input type="checkbox"/> Anti-seizure medication (like Dilantin, Tegretol, Depakote, or Trileptal)
<input type="checkbox"/> Accutane (anti-acne)	<input type="checkbox"/> Lithium, Depakote, or Tegretol for bipolar/behavior disorder
<input type="checkbox"/> Anticoagulants (blood thinners)	<input type="checkbox"/> ACE inhibitors (blood pressure medications like Zestril, Capoten, etc.)
3. Are you and the father of the baby related by blood (e.g. cousins)? Yes No

If you have answered YES to any of the above questions, your pregnancy may have a higher chance for birth defects or inherited conditions. The Genetics Department can provide more information about the specific risks for your pregnancy and discuss the availability of testing during pregnancy. **A Genetic Counselor will review the above information and contact you only if your pregnancy appears to have a higher risk.** You may also contact the Genetics department directly to discuss your concerns. (Phone number listed above)

I do NOT wish to discuss my family history and/or medication use with a Genetic Counselor.

If you have concerns that are not addressed by the above questions, please discuss them with your OB provider to see if you may benefit from genetic counseling.

Patient signature: _____ **Date:** _____

Referred to Genetics by: _____ Date: _____

OB Provider Review: _____ Date: _____