Madison Women's Health LLP

Genetic Screening Questionnaire

Patient Name	Date of Birth	Today's Date	MRN

Please complete this form and bring with you to your first appointment.

1. Will you be 35 years or older when your baby is due?

   ☐ Yes ☐ No

2. Have you or the baby's father, or anyone in either family ever had a genetic disease or birth defect? If yes, check below.

   ☐ Anencephaly ☐ Bone abnormality ☐ Cleft lip or cleft palate
   ☐ Cystic fibrosis ☐ Congenital heart defect ☐ Genital abnormality
   ☐ Hydrocephaly ☐ Limb deformity ☐ Mental retardation
   ☐ Muscular dystrophy ☐ Neurofibromatosis ☐ Neurologic disorders
   ☐ Sickle cell disease ☐ Spina bifida (open spine) ☐ Tay-Sachs disease
   ☐ Thalassemia ☐ Vision loss ☐ Hearing loss
   ☐ Bleeding disorder ☐ Kidney/urinary tract abnormalities
   ☐ Down Syndrome or other chromosome disorder
   ☐ Other: _____

3. Have you or the baby's father had a child that was stillborn? ☐ Yes ☐ No

4. Are you or the baby's father from any of the following ethnic/racial groups?

   ☐ African American/African ☐ Hispanic
   ☐ Eastern European Jewish (Ashkenazi) ☐ French Canadian
   ☐ Asian (including Indian & Pakastani) ☐ Cajun
   ☐ Mediterranean

5. Have you taken any prescription, over-the-counter drugs, street drugs including alcohol or been exposed to radiation, during this pregnancy?

   ☐ Yes ☐ No If "Yes", explain: _____

6. Have you had a fever of 102 or greater during this pregnancy? ☐ Yes ☐ No

7. Are you and the baby's father related by blood (e.g., first/second cousins)? ☐ Yes ☐ No