Stanford MEDICINE
Women's Care Medical Group

GENETIC SCREENING OUESTIONNAIRE

Medical Record Number

Patient Name

Addressograph or Label

This questionnaire will provide us with information about your genetic background with the goal of helping you plan for a healthy baby.

Frequently, a specific genetic disorder will run in a given family. Also, certain disorders are found more often in people of a particular ethnic background. If you are in a high risk group based on family history or ethnic background, there may be laboratory tests which can determine whether you or your children are carriers of genetic disorders. It is better to do these tests before you are pregnant or very early in pregnancy.

Your participation in answering this questionnaire is voluntary. All information obtained will remain confidential.

Answer the questions as well as you can. If you don't understand the words, or are unsure if someone in your family had the problem, check "Don't Know" and ask your nurse or doctor.

Please answer every question.

			Yes	No	Don't Know
1		Are you pregnant? If yes, what was the first day of your last menstrual period? _____	☐	☐	☐
2		Are you 33 years of age or older?	☐	☐	☐
3		Is your partner 50 years of age or older?	☐	☐	☐
4		Have you, your partner or anyone in either family (children, sisters, brothers, nieces, nephews, parents, aunts or uncles) had any of the following:			
	a	Birth defects (describe below)	☐	☐	☐
	b	Intellectual disability or mental deterioration	☐	☐	☐
	c	Unexplained infant or childhood deaths	☐	☐	☐
	d	Chromosome disorders (Down Syndrome, mongolism, trisomy 13 or 18, translocations – describe below)	☐	☐	☐
	e	Two or more miscarriages	☐	☐	☐
	f	Enzyme or metabolic diseases	☐	☐	☐
	g	Spina bifida, anencephaly (malformations of the brain or openings in the spine)	☐	☐	☐
	h	Hydrocephalus "water-on-the-brain"	☐	☐	☐
	i	Congenital heart malformations	☐	☐	☐
	j	Malformations of other organs (describe below)	☐	☐	☐
	k	Muscular dystrophy, myotonic dystrophy or progressive muscle wasting	☐	☐	☐
	l	Hemophilia (blood clotting problems)	☐	☐	☐
	m	If you answered yes to any of the above, explain in whom:			
5		Do you, your children, parents, sisters, brothers, nieces, nephews, aunts or uncles have any birth defects or inherited disorders not listed in Question 4? If yes, please explain:	☐	☐	☐

Please complete reverse side.

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			You			Your Partner		
			Yes	No	Don't Know	Yes	No	Don't Know
6		Is there any of the following background in your family or your partners family?						
	a	Jewish	☐	☐	☐	☐	☐	☐
		If yes, have you been tested for Tay-Sachs disease?	☐	☐	☐	☐	☐	☐
	b	Black	☐	☐	☐	☐	☐	☐
		If yes, have you been tested for Sickle Cell trait?	☐	☐	☐	☐	☐	☐
	c	Asian (Oriental) or Mediterranean (Greek, Italian)	☐	☐	☐	☐	☐	☐
		If yes, physician please check MCV, as a screen for thalassemia carrier status.	☐	☐	☐	☐	☐	☐

			Yes	No	Don't Know
7		Do you have any of the following disorders?			
	a	Insulin dependent diabetes	☐	☐	☐
	b	Autoimmune disorders such as lupus or rheumatoid arthritis	☐	☐	☐
	c	Seizures or convulsions	☐	☐	☐
8		Are you taking or do you use any of the following:			
	a	Lithium	☐	☐	☐
	b	Valium	☐	☐	☐
	c	Accutane (a drug for acne)	☐	☐	☐
	d	Anticoagulants	☐	☐	☐
	e	Anticonvulsants (drugs for seizure such as Dilantin, Phenobarbital)	☐	☐	☐
	f	Iodides to treat hyperthyroidism	☐	☐	☐
	g	Anticancer drugs	☐	☐	☐
	h	Birth control pills during pregnancy	☐	☐	☐
	i	Alcohol	☐	☐	☐
	j	Other drugs, please list:	☐	☐	☐
9		Are there health problems in you or your family that concern you? If so, please explain:	☐	☐	☐

Comments: