Eastside MATERNAL FETAL MEDICINE

The following questions will help your provider complete a risk assessment and determine if certain tests are appropriate.
If you are unsure about your family history, please speak with family members.

RACE/ETHNICITY: Please circle and check all that apply:

	Patient	Partner
Chinese, Taiwanese, Asian Indian, Pakistani, Filipino, Pacific Islander or Southeast Asian	☐	☐
Japanese or Korean	☐	☐
Italian, Greek, Middle Eastern, Spanish or Portuguese	☐	☐
Jewish, French Canadian or Cajun	☐	☐
African American, African descent, Black, Puerto Rican, Caribbean or Central American	☐	☐
Hispanic or Mexican	☐	☐
Caucasian	☐	☐
Other (specify) _____	☐	☐

FAMILY HISTORY: Have you, your partner or anyone in your families ever had the following conditions?

	Yes	No		Yes	No
Down syndrome	☐	☐	heart defect	☐	☐
other chromosome condition	☐	☐	cleft lip/cleft palate	☐	☐
mental retardation, autism, developmental delay	☐	☐	blindness / deafness	☐	☐
spina bifida (open spine) or			blood disorder, such as Hemophilia or Sickle Cell	☐	☐
anencephaly (open head/brain)	☐	☐	stroke or blood clot at age less than 50	☐	☐
Cystic Fibrosis (a lung disease)	☐	☐	any other birth defect/genetic/inherited condition	☐	☐
Muscular Dystrophy or neuromuscular disease	☐	☐	please list_____		
skeletal disorder, like dwarfism	☐	☐	any other serious medical condition or surgery	☐	☐
Polycystic kidney disease	☐	☐	please list_____		

	Yes	No
Are you and your partner related to each other - other than by marriage?	☐	☐
Is there a history of infertility in either you and/or your partner?	☐	☐
Please specify the cause of infertility, if known. _____		
Have you ever had a miscarriage.	☐	☐
If yes, how many times?_____ How far along was/were the pregnancy(s)?_____		
Have you or your partner (with a previous partner) ever had a still birth.	☐	☐
Have you or your partner (with a previous partner) ever had an infant death.	☐	☐
Have you ever had a baby born small for its age, or that the doctors delivered early because it was small?	☐	☐
Have you had a history of high blood pressure and/or preclampsia in prior pregnancies?	☐	☐

PERSONAL HISTORY: Please complete the following patient information:

	Yes	No		Yes	No
Was this pregnancy achieved with IVF?	☐	☐	Since you have been pregnant:		
If yes, did you use:			had any bleeding/spotting?	☐	☐
donor egg (age of donor____) or donor sperm?	☐	☐	had any pelvic or abdominal pain?	☐	☐
preimplantation genetic diagnosis/screening (PGD/PGS)	☐	☐	had severe morning sickness ?	☐	☐
Do you have diabetes (type 1 or type 2)?	☐	☐	have you taken any medication?	☐	☐
Do you have lupus or Sjogren's syndrome?	☐	☐	Please list:_____		
Do you have PKU or Marfan Syndrome?	☐	☐	had any alcoholic drinks?	☐	☐
Do you have any questions regarding the estimated			smoked any cigarettes?	☐	☐
due date as determined by your Provider?	☐	☐	used any recreational drugs?	☐	☐
Do you have a history of irregular/missed periods	☐	☐	had any rashes, infections, fevers?	☐	☐
Do you have a history of substance abuse?	☐	☐	had exposure to any x-rays (other than dental)?	☐	☐

I have answered these questions to the best of my knowledge.

Patient's signature _____ **Date** _____

If "yes" response or ethnicity screening indicated, genetic counseling offered:

I accept genetic counseling _____ **Patient's initials**

I decline genetic counseling _____ **Patient's initials**

MD / GC _____