

Genetic / Family History Questionnaire

Patient Name: _____ **Date:** _____

Social Security Number: _____

How would you describe your ancestry (check all that apply):

- | | | | |
|---|--|--|--|
| <input type="checkbox"/> White | <input type="checkbox"/> French Canadian | <input type="checkbox"/> Samoan | <input type="checkbox"/> Vietnamese |
| <input type="checkbox"/> African (Black) | <input type="checkbox"/> Native American | <input type="checkbox"/> Chinese | <input type="checkbox"/> Laos |
| <input type="checkbox"/> Hispanic | <input type="checkbox"/> Greek | <input type="checkbox"/> Cambodian | <input type="checkbox"/> Taiwanese |
| <input type="checkbox"/> Ashkenazi Jewish | <input type="checkbox"/> Italian | <input type="checkbox"/> Filipino | <input type="checkbox"/> Korean |
| <input type="checkbox"/> Cajun | <input type="checkbox"/> Middle Eastern | <input type="checkbox"/> Japanese | <input type="checkbox"/> Other Southeast Asian |
| <input type="checkbox"/> Guamanian | <input type="checkbox"/> Hawaiian | <input type="checkbox"/> Asian-East Indian | <input type="checkbox"/> Unknown Race |
| <input type="checkbox"/> Other _____ | <input type="checkbox"/> Other _____ | | |

Are you and the father of this baby a blood relative (example: cousins)? Yes No

What is your occupation? _____

What is the name of the father of this baby? _____

What is the occupation of the father of this baby? _____

What is the age of the father of this baby? _____

How would you describe the ancestry of the father of this baby (check all that apply):

- | | | | |
|---|--|--|--|
| <input type="checkbox"/> White | <input type="checkbox"/> French Canadian | <input type="checkbox"/> Samoan | <input type="checkbox"/> Vietnamese |
| <input type="checkbox"/> African (Black) | <input type="checkbox"/> Native American | <input type="checkbox"/> Chinese | <input type="checkbox"/> Laos |
| <input type="checkbox"/> Hispanic | <input type="checkbox"/> Greek | <input type="checkbox"/> Cambodian | <input type="checkbox"/> Taiwanese |
| <input type="checkbox"/> Ashkenazi Jewish | <input type="checkbox"/> Italian | <input type="checkbox"/> Filipino | <input type="checkbox"/> Korean |
| <input type="checkbox"/> Cajun | <input type="checkbox"/> Middle Eastern | <input type="checkbox"/> Japanese | <input type="checkbox"/> Other Southeast Asian |
| <input type="checkbox"/> Guamanian | <input type="checkbox"/> Hawaiian | <input type="checkbox"/> Asian-East Indian | <input type="checkbox"/> Unknown Race |
| <input type="checkbox"/> Other _____ | <input type="checkbox"/> Other _____ | | |

Is the father of this baby your partner? Yes No

Comments:

Genetic / Family History Questionnaire

Do you, the father of this baby, or any close relatives have:

- | | | |
|---|------------------------------|-----------------------------|
| 1. Thalassemia (Greek, Mediterranean, or Asian Background) MCV < 80 | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 2. Neural Tube Defect (Meningomyelocele Spina Bifida, or Anencephaly) | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 3. Congenital Heart Defect | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 4. Down Syndrome | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 5. Tay-Sachs (EG, Jewish, Cajun, French Canadian) | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 6. Sickle Cell Disease or Trait (African) | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 7. Hemophilia or bleeding problems | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 8. Muscular Dystrophy | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 9. Cystic Fibrosis | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 10. Canavan Disease | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 11. Mental Retardation / Autism / Learning Disorder | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| If Yes: Tested for Fragile X <input type="checkbox"/> Yes <input type="checkbox"/> No | | |
| 12. Huntington Chorea | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 13. Other inherited genetic or chromosomal disorder | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 14. Maternal Metabolic Disorder (EG, Insulin-Dependent Diabetes, PKU) | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 15. Patient or baby's father had a child with birth defects not listed above | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 16. Recurrent pregnancy loss, or stillbirth | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 17. Blindness or deafness | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 18. Bone or skeletal disorder (Dwarfism) | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 19. Breast, ovarian or colon cancer | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 20. Kidney disorder | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 21. Do either you or any of your parents, siblings, or children have diabetes | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 22. Blood clots / stroke | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 23. Have you taken any medications other than PN vitamins since becoming pregnant? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| If yes, what type: _____ | | |
| 24. Have you used any street drugs since becoming pregnant? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| If yes, what type: _____ | | |
| 25. Have you consumed any alcoholic beverages since becoming pregnant? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| If yes, what type: _____ | | |
| 26. Any other | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 27. Anything that seems to run in the family | <input type="checkbox"/> Yes | <input type="checkbox"/> No |

Comments:

Reviewed By: _____

Review of Systems Questionnaire

Do you or have you taken any medication in the last year:

Medications Taken	Date Taken

Do you have any known allergies?

Do you currently smoke?

<input type="checkbox"/> Yes	<input type="checkbox"/> No
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Past Surgeries:
