OBSTETRIX MEDICAL GROUP

Genetic / Family History Questionnaire

Patient Name: _____ Date: _____

Social Security Number: _____

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

__ White	__ French Canadian	__ Samoan	__ Vietnamese
__ African (Black)	__ Native American	__ Chinese	__ Laos
__ Hispanic	__ Greek	__ Cambodian	__ Taiwanese
__ Ashkenazi Jewish	__ __ Italian	__ Filipino	__ Korean
__ Cajun	__ Middle Eastern	__ Japanese	__ Other Southeast Asian
__ Guamanian	__ Hawaiian	__ Asian-East Indian	__ Unknown Race
__ Other _____		__ 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):

__ White	__ French Canadian	__ Samoan	__ Vietnamese
__ African (Black)	__ Native American	__ Chinese	__ Laos
__ Hispanic	__ Greek	__ Cambodian	__ Taiwanese
__ Ashkenazi Jewish	__ __ Italian	__ Filipino	__ Korean
__ Cajun	__ Middle Eastern	__ Japanese	__ Other Southeast Asian
__ Guamanian	__ Hawaiian	__ Asian-East Indian	__ Unknown Race
__ Other _____		__ Other _____	

Is the father of this baby your partner? __ Yes __ No

Comments:

_____
_____
_____
_____
_____
_____

Revised: 2/10/2012

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

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

Comments:

_____
_____
_____
_____
_____

Reviewed By: _____

Revised: 2/10/2012

OBSTETRIX MEDICAL GROUP

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?

__ Yes	**__ No**

Past Surgeries:
