OBSTETRIX MEDICAL GROUP
an affiliate of MEDNAX

Genetic/Family History Questionnaire

Patient Name: _____Date of Birth: _____Date: _____

How would you describe your ancestry? Please 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 Southeastern Asian
☐ Guamanian	☐ Hawaiian	☐ Asian- East Indian	☐ Unknown Race
☐ Other: _____		☐ Other: _____	

Are you and the father of this baby a blood relative (i.e. 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? Please 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 Southeastern Asian
☐ Guamanian	☐ Hawaiian	☐ Asian- East Indian	☐ Unknown Race
☐ Other: _____		☐ Other: _____	

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

Is this pregnancy a Product of IVF? Yes ☐ No ☐ If yes:

Was a donor egg used? Yes ☐ No ☐

What is the age of the donor? _____

Comments: _____

_____

_____

Revised 04/2019

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

Thalassemia (Greek, Mediterranean, or Asian Background) MCV < 80	Yes	No
Neural Tube Defect (Meningomyelocele Spina Bifida or Anencephaly)	Yes	No
Congenital Heart Defect	Yes	No
Down syndrome	Yes	No
Tay-Sachs (Jewish, Cajun, French Canadian)	Yes	No
Sickle Cell Disease or Trait (African)	Yes	No
Hemophilia or Bleeding Problems	Yes	No
Muscular Dystrophy	Yes	No
Cystic Fibrosis	Yes	No
Canavan Disease	Yes	No
Mental Retardation / Autism / Learning Disorder	Yes	No
If Yes, Tested for Fragile X	Yes	No
Huntington Chorea	Yes	No
Other inherited Genetic or Chromosomal Disorder	Yes	No
Maternal Metabolic Disorder (insulin Dependent Babies, PKU)	Yes	No
Patient or Baby's father had a child with birth defects NOT listed above?	Yes	No

If yes, describe _____

Recurrent pregnancy Loss or Stillbirth	Yes	No
Blindess or Deafness	Yes	No
Bone or Skeletal Disorder (Dwarfism)	Yes	No
Breast, Ovarian, Or Colon Cancer	Yes	No
Kidney Disorder	Yes	No
Do either of you or any of your parents, siblings or children have Diabetes?	Yes	No
Blood/Clots / Stroke	Yes	No
Have you taken any medications other than Prenatal Vitamins since pregnancy?	Yes	No
Have you used any street drugs since becoming pregnant?	Yes	No

If yes, please list substance: _____ How often? _____

Have you consumed any alcoholic beverages since becoming pregnant?	Yes	No

If yes, please list substance: _____ How often? _____

Do you currently smoke?	Yes	No
Anything else that runs in the family? _____	Yes	No

Comments: _____

_____

Reviewed By: _____

Have you been screen to see if you are a carrier for inherited disease such as **cystic fibrosis, thalassemia, sickle cell trait, spinal muscular atrophy (SMA), or Fragile X?** Yes ☐ No ☐

If so, are you a carrier of any known inherited disease? Yes ☐ No ☐
If yes, which one(s)? _____

Have you or your partner travelled to Florida this pregnancy, or anywhere outside the United States?
Yes ☐ No ☐
If yes, where and when? _____

Do you have a history of preeclampsia in any previous pregnancy? Yes ☐ No ☐

Preferred Pharmacy: _____ Phone Number: _____

Review of Systems Questionnaire

Do you or have you taken medication in the last year?

Medications Taken	Dose	Frequency	Date Started

Do you have any known drug allergies?

Drug	Reaction	Severity (mild, moderate, or severe)

Do you have a past or current history of any Psychiatric Disorders, Depression, or Postpartum Depressions?

Yes ☐ No ☐ If yes, please state the condition(s) and when diagnosed.

Date	Condition

Past Surgeries: (Example: Appendectomy, Cervical Conization, LEEP, Laparoscopy, Hysteroscopy)

Surgery	Date

Do you have any medical problems (Example: Diabetes, High Blood Pressure, Thyroid)?

Medical Issue	Date

Previous Pregnancies:

Year	Outcome (full term, preterm, miscarriage, termination)	Type of delivery (vaginal cesarean, forceps, vacuum)	Weight and Gender	Complications