Genetic/Family History Questionnaire

Patient Name:____________________________________
Social Security Number:___________________________
Date:____

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_____________________________			

Are you and the father of this baby blood relatives (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_____________________________			

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

Comments____
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Genetic/Family History Questionnaire – continued

Do you, the father of this baby, or any close relatives have any of the following conditions?

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 or canavan disease □ Yes □ No
10. Mental retardation / autism / learning disorder □ Yes □ No
    If yes: tested for fragile X □ Yes □ No
11. Huntington chorea □ Yes □ No
12. Other inherited genetic or chromosomal disorder □ Yes □ No
13. Maternal metabolic disorder (EG, insulin-dependent diabetes, PKU) □ Yes □ No
14. Patient or baby's father had a child with birth defects not listed above □ Yes □ No
15. Recurrent pregnancy loss, or stillbirth □ Yes □ No
16. Blindness or deafness □ Yes □ No
17. Bone or skeletal disorder (dwarfism) □ Yes □ No
18. Breast, ovarian or colon cancer □ Yes □ No
19. Kidney disorder □ Yes □ No
20. Do either you or any of your parents, siblings, or children have diabetes □ Yes □ No
21. Blood clots / stroke □ Yes □ No
22. Have you taken any medications other than PN vitamins since becoming pregnant? □ Yes □ No
    If yes, what type:____
23. Have you used any street drugs since becoming pregnant? □ Yes □ No
    If yes, what type:____
24. Have you consumed any alcoholic beverages since becoming pregnant? □ Yes □ No
    If yes, what type:____
25. Any other conditions that run in the family? □ Yes □ No
    If yes, what type:____

Comments____

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Reviewed By: ________________________________