OBSTETRIX® MEDICAL GROUP

Patient Name: ______________________________
Social Security Number: ____________________
Date: ____________________

Genetic / Family History Questionnaire

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 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 ____________		☐ Other ____________	

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

Comments:
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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 ☐ 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 ☐ Yes ☐ No
26. Anything that seems to run in the family ☐ Yes ☐ No

Comments: ______________________________

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Reviewed By ______________________________