

## Pregnancy and Family History Questionnaire

**Name:** \_\_\_\_\_ **DOB:** \_\_\_\_\_ **Occupation:** \_\_\_\_\_

**Preferred Contact Number:** \_\_\_\_\_ **Referring Physician:** \_\_\_\_\_

**Partner's Name:** \_\_\_\_\_ **DOB:** \_\_\_\_\_ **Occupation:** \_\_\_\_\_

*Please answer the following questions and provide an explanation when applicable. If you have any questions, then your genetic counselor will review the questionnaire with you.*

**Are you or your partner from any of these ethnic backgrounds? Please check all that apply.**

- |   |   |   |  |
|---|---|---|--|
| <input type="checkbox"/> Caucasian                            | <input type="checkbox"/> African American | <input type="checkbox"/> Asian          | <input type="checkbox"/> Hispanic                |
| <input type="checkbox"/> Jewish                               | <input type="checkbox"/> African          | <input type="checkbox"/> Asian Indian   | <input type="checkbox"/> Central American        |
| <input type="checkbox"/> Mediterranean (Greek, Italian, etc.) | <input type="checkbox"/> Caribbean        | <input type="checkbox"/> Middle Eastern | <input type="checkbox"/> Cajun / French Canadian |
| <input type="checkbox"/> Other: _____                         |   |   |  |

**Have you, your partner, or anyone in your families ever had the following conditions:**

|                                      | Yes | No |  | Yes | No |
|--------------------------------------|-----|----|--|-----|----|
| 1. Down syndrome                     |     |    | 8. Three or more pregnancy losses              |     |    |
| 2. Other chromosome abnormality      |     |    | 9. Infant or childhood death                   |     |    |
| 3. Intellectual disability or autism |     |    | 10. Stillborn                                  |     |    |
| 4. Spina bifida (open spine)         |     |    | 11. Other inherited or genetic condition       |     |    |
| 5. Heart defect at birth             |     |    | 12. Other serious medical condition or surgery |     |    |
| 6. Cleft lip/ Cleft palate           |     |    | 13. Any birth defect not listed above          |     |    |
| 7. Blindness/ Deafness               |     |    | 14. Other:                                     |     |    |

**Please complete the following patient information pertaining to this current pregnancy.**

- |   |            |           |
|---|------------|-----------|
|   | <b>Yes</b> | <b>No</b> |
| 1. Are you taking any medications?<br>Please List: _____  | [ ]        | [ ]       |
| 2. Have you had exposure to alcohol, recreational drugs, cigarettes or X-rays?  | [ ]        | [ ]       |
| 3. Was an egg/sperm/embryo donor used to achieve this pregnancy?  | [ ]        | [ ]       |
| 4. Was IVF or IVF with ICSI used to achieve this pregnancy? Any PGS/PGD?  | [ ]        | [ ]       |
| 5. Have you had prenatal screening or NIPT (e.g. Panorama/MaterniT21/"nuchal" screen)?  | [ ]        | [ ]       |
| 6. Have you or your partner had carrier testing for any genetic conditions in this pregnancy or a previous pregnancy (e.g. Cystic Fibrosis, Tay-Sachs disease, etc.)? | [ ]        | [ ]       |

What is your Due Date? \_\_\_\_\_

Patient Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Reviewed by: \_\_\_\_\_ Date: \_\_\_\_\_