AMA
AMERICAN
MEDICAL
ASSOCIATION

**Prenatal Screening Questionnaire**

Filling out and printing this form prior to an appointment with a geneticist or genetic counselor would be helpful for the specialist.

**Father of the Pregnancy**

Name_____

DOB (00/00/00)_____ Age _____

Ethnic Origin / Religion_____

Occupation_____

**Mother of the Pregnancy**

Name_____

DOB (00/00/00)_____ Age _____

Ethnic Origin / Religion_____

Occupation_____

**Family and Patient History**
Does your family or the father of the baby's family have the following ethnic background:

Yes No

_____ _____ Southeast Asia, Taiwan, China, or the Philippines

_____ _____ Italy, Greece, or the Middle East

If yes to the previous two questions, have you or your partner been tested for thalassemia? Yes_____No_____

Yes No

_____ _____ Eastern European (Ashkenazi) Jewish

_____ _____ French Canadian

If yes to the previous two questions, have you or your partner been tested for Tay Sachs? Yes_____No_____

Yes No

_____ _____ African American, African, or Black

If yes to the previous question, have you or your partner been tested for sickle cell anemia? Yes_____No_____

Have you, the baby's father, or anyone in either of your families ever had any of the following? If "yes", please explain at the bottom in the space provided:

| Yes | No | |
|---|---|---|
| _____ | _____ | Down Syndrome |
| _____ | _____ | Other Chromosome Abnormalities |
| _____ | _____ | Neural Tube Defect (e.g. spina bifida, anencephaly) |
| _____ | _____ | Hemophilia or Other Bleeding Disorders |
| _____ | _____ | Cystic Fibrosis |
| _____ | _____ | Sickle Cell Anemia |
| _____ | _____ | Thalassemia(Mediterranean anemia) |
| _____ | _____ | Tay Sach's Disease |
| _____ | _____ | Muscular Dystrophy |
| _____ | _____ | Neurofibromatosis |
| _____ | _____ | Huntington's Disease |
| _____ | _____ | Other Nerve, Muscle or Seizure Disorder (e.g. epilepsy) |
| _____ | _____ | Phenylketonuria (PKU) |
| _____ | _____ | Kidney Disease |
| _____ | _____ | Heart Defect (from birth) |
| _____ | _____ | Cleft Lip and/or Cleft Palate |
| _____ | _____ | Limb Defects (extra or missing digits, malformed arms, legs, hands or feet) |
| _____ | _____ | Deafness / Early Onset Hearing Loss |
| _____ | _____ | Blindness / Early Onset Vision Loss |
| _____ | _____ | Diabetes |
| _____ | _____ | Cancer before age 50 |
| _____ | _____ | Heart Attack before age 40 |
| _____ | _____ | Do you or the baby's father have any relatives with mental retardation or developmental delay? |

| Yes | No | |
|---|---|---|
| _____ | _____ | Does anyone in either of your families have a genetic defect, or chromosome abnormality not listed above? |
| _____ | _____ | Have you or the baby's father had a baby that died shortly after birth or in the first year? |
| _____ | _____ | Have you or the baby's father had a stillborn child, or three or more first trimester miscarriages? |
| _____ | _____ | Are you and the baby's father blood-related in any way (i.e., cousins, uncle-niece, etc.)? |
| _____ | _____ | Is there any other family history that you have concerns about? |

**Pregnancy History**
During this pregnancy, have you had any of the following? If "yes", please describe, including dates, if known, in the space provided at the bottom:

| Yes | No | |
|---|---|---|
| _____ | _____ | Uterine cramping, vaginal bleeding (spotting) or vaginal leakage of fluid |
| _____ | _____ | Infections, rashes, or other illness, fever over 101 degrees |
| _____ | _____ | X-rays, hospitalizations, or surgery |
| _____ | _____ | Cigarettes, alcoholic beverages, or "street" drugs |
| _____ | _____ | Ultrasound ("sonogram") |
| _____ | _____ | Occupational, chemical, or other exposures |
| _____ | _____ | Prescription or non-prescription medications |
| _____ | _____ | Prenatal vitamins |

**Comments from above**

_____

_____

_____

_____

_____

_____

**My signature below indicates that the above family and pregnancy history information provided is complete and correct.**

_____ _____
Signature of person completing form Today's date

**For office use only**

G_____ P_____ Sab_____ Tab_____ St.Bth._____ Ectopic_____ Other _____

LMP_____ Wks. Gestation_____ EDC _____

**Plan/Indications:**

_____

_____

_____

_____

_____

_____
Geneticist/Genetic Counselor