The OB/GYN Group of Austin

Genetic Screening Questionnaire

NAME: _____

Will you be 35 years old or older at your due date?	Y	N
Are you or your baby's father of…		
• Jewish background?	Y	N
• Black/African background?	Y	N
• Mediterranean background?	Y	N
• Asian background?	Y	N
• French-Canadian background?	Y	N
Have you…		
• Taken any medications (prescribed or OTC) during this pregnancy?	Y	N
• Had any alcohol (beer, wine, hard liquor) during this pregnancy?	Y	N
• Used any illegal/street drugs (cocaine, marijuana) during this pregnancy?	Y	N
• Taken Accutane, blood thinners, or lithium since your last period?	Y	N
• Had radiation therapy or chemotherapy since your last period?	Y	N
• Take mega dose vitamins, especially vitamin A since your last period?	Y	N
Do you or your baby's father have epilepsy?	Y	N
• And take medication? If yes type _____	Y	N
Do you have diabetes or have you had diabetes with pregnancy and are/were you…	Y	N
• On insulin	Y	N
• On oral hypoglycemic medications	Y	N
• Controlled by diet	Y	N
Are you and the father of your baby first cousins or closer?	Y	N
Have you had…		
• Three or more miscarriages?	Y	N
• A stillborn infant?	Y	N
• A child that died within the first year of life?	Y	N

Have you, the father of your baby, or anyone in either family ever had a child	**Self**	**Father**	**Family**
• With Down Syndrome or other chromosomal abnormality?	Y N	Y N	Y N
• With mental retardation?	Y N	Y N	Y N
• With an open spine (spina bifida), skull defect, or anencephaly?	Y N	Y N	Y N
• With a heart defect?	Y N	Y N	Y N
• With a muscle or neuromuscular disease (muscular dystrophy)?	Y N	Y N	Y N
• With Cystic Fibrosis?	Y N	Y N	Y N
• With Hemophilia, sickle cell, thalassemia, or other blood disorders?	Y N	Y N	Y N
• With any birth defect or genetic disease not listed above?	Y N	Y N	Y N

Patient signature_____date_____