PAMF Prenatal Genetic Screening Questionnaire

(Please Print)

Patient Name: ________________________________ Partner Name: ________________________________

Patient Date of Birth: ________________________________ Partner Date of Birth: ________________________________

Patient Occupation: ________________________________ Partner Occupation: ________________________________

Patient Countries of Ancestry: ________________________________ Partner Countries of Ancestry: ________________________________

Family and Patient History

*Close relative indicates child, mother, father, sister, brother, aunt, uncle, or grandparent

1. Do you, the baby’s father or anyone in either of your families have or had any of the following disorders?
   a. Down syndrome □ No □ Yes
   b. Other chromosomal abnormalities □ No □ Yes
   c. Neural tube defect (spina bifida, anencephaly) □ No □ Yes
   d. Heart defect (at birth) □ No □ Yes
   e. Cleft lip/palate □ No □ Yes
   f. Kidney abnormalities □ No □ Yes
   g. Cystic fibrosis (lung disease) □ No □ Yes
   h. Nerve or muscular disorder (neurofibromatosis, muscular dystrophy) □ No □ Yes
   i. Bone or skeletal disorder (dwarfism) □ No □ Yes
   j. Blood disorder (hemophilia, sickle cell, thalassemia, clotting disorder) □ No □ Yes
   k. Blindness/deafness at a young age □ No □ Yes
   l. Cancer in childhood or young adulthood □ No □ Yes

2. Are you and the baby’s father related by blood: for example, cousins? □ No □ Yes

3. Do you or the baby’s father have any close relatives* with mental retardation? □ No □ Yes
   Please indicate the cause if known: ________________________________

4. Have you, the baby’s father, or anyone in either of your families needed surgery before one year of age? □ No □ Yes

5. Other Medical Problems
   a. Do you, the baby’s father or a close relative* in either of your families have a genetic condition or chromosome abnormality not listed above? □ No □ Yes
   b. Do you, the baby’s father or a close relative* in either of your families have a birth defect not listed above? □ No □ Yes
   c. Do you, the baby’s father, or a close relative* in either of your families have a serious medical problem that you are concerned about (such as diabetes)? □ No □ Yes

6. Previous Pregnancy
   a. Have you or the baby’s father had a baby who died shortly after birth or in the first year? □ No □ Yes
   b. Have you or the baby’s father had a stillborn child or two or more first trimester spontaneous pregnancy losses? □ No □ Yes

7. Was this pregnancy achieved through in-vitro fertilization (IVF) or other assisted reproductive methods? □ No □ Yes
   If yes, was there: □ Sperm donor □ Egg donor □ ICSI □ Other: ________________________________

8. Have you or the baby’s father had any genetic tests (such as sickle cell, thalassemia, cystic fibrosis, Tay-Sachs, Canavan screening)? □ No □ Yes

9. Excluding vitamins and iron, have you used medications, street drugs, tobacco, or alcohol since being pregnant or since your last menstrual period? □ No □ Yes

10. Have you had the California Prenatal Screening Program blood test in this pregnancy? □ No □ Yes

11. Have you had Non-invasive Prenatal Testing (NIPT)? □ No □ Yes

12. If Yes to any questions above, please explain: __________________________________________________________
    _______________________________________________________

Completed by: ________________________________ Date: ________________________________

Reviewed by: ________________________________ Date: ________________________________