McMorries

OBSTETRICS, GYNECOLOGY & INFERTILITY

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OB/GYN GENETIC SCREENING FORM

1. Patient's Name: Home Phone: _____ Work Phone: _____

_____

Last First Maiden Birth Date Age

Name of the Father of the Child:

_____

Last First Maiden Birth Date Age

2. Pregnancy History: Number of Pregnancies ____ Number of Livebirths ____ Number of Stillbirths ____ Number of Miscarriages/Abortions ____

Delivery Dates (living and deceased) Sex Health Status Birth Weight Was Father Different From Above?

_____

_____

_____

_____

3. Are you and the father of this pregnancy blood relatives? _____

4. Are there inherited disorders, or any birth defects, in the families of you or of the father of this pregnancy? If yes, list:

_____

_____

5. Do you have any belief that would change the type of medical care you prefer to receive? ____ For example, are you a Jehovah's Witness? ____

6. If you or the child's father identify within one or more of the following demographics, please circle which may apply and answer the corresponding questions.

Black Indian Eastern Mediterranean
Have you and/or the child's father or any family members had the diagnosis of Sickle Cell Anemia or Sickle Cell Trait or had Sickle Cell Anemia Carrier test?_____

Jewish
Have you and/or the child's father or any family members had Tay-Sachs carrier testing, or have any family members had Tay-Sachs disease? _____

Italian Greek Asian African
Have you and/or the child's father or any family members had any form of Thalassemia or had Thalassemia carrier testing? _____

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7. Please list any medicines (prescription or over the counter) taken since becoming pregnant: _____

_____

Do you use any drugs (street, illegal, recreational) not listed above? __ If yes, please list: _____

Have you been exposed to any x-rays, chemicals, or environmental hazards since this pregnancy? __ If yes, please list: _____

_____

Have any of the following disorders, or other disorders, occurred in you or the father of this child or in the families of either of you (parents, children, sisters, brothers, and descendants)? Please provide at the bottom of this sheet IN DETAIL all information on ANY disorder you check. If possible, please bring any medical records documenting the occurrence of this disorder. If there is no family history of birth defects or disorders, please list "NONE" and your initials. _____

____ Infant or Childhood Deaths
____ Stillbirths
____ Mental Retardation
____ Downs Syndrome (mongolism)
____ Spina Bifida (open spine)
____ Anencephaly
____ Hydrocephaly (water on the brain)
____ Sickle Cell Anemia or Trait
____ Tay-Sachs Disease or Carrier
____ Thalassemia
____ Cystic Fibrosis
____ Galactosemia
____ Phenylketonuria (PKU)
____ Hemophilia or Bleeding Disorder
____ Muscular Dystrophy or any Muscle Disorder
____ Birth Defects (list below)
____ Huntington's Chorea
____ Acute Intermittent Porphyria
____ Cleft Lip or Palate
____ Congenital Heart Disease/Defect
____ Blindness
____ Deafness
____ Polycystic Kidney Disease
____ Any Skeletal (bone) Disorder
____ Dwarfism (short stature)
____ Multiple Miscarriages
____ Enzyme or Metabolic Disease
____ Other known or suspected inherited or genetic conditions:
_____
_____

9. Do you have reason to believe that you have been exposed to AIDS? ____ YES ____ NO
Have you ever had any blood transfusions? ____ YES ____ NO

10. Do you currently or have you ever had a viral infection known as herpes? ____ YES ____ NO

11. Do you have any other concerns or history not covered above? ____ YES ____ NO

IF ANY OF YOUR RESPONSES IN THIS FORM WERE "YES", EXPLAIN WHO IN THE FAMILY IS AFFECTED AND PROVIDE THE MEDICAL DETAILS BELOW IN DETAIL:

_____

_____

_____

Signature of Patient: _____ Date: _____