Lucile Salter Packard Children's Hospital
STANFORD UNIVERSITY MEDICAL CENTER
725 Welch Road Palo Alto, CA 94304

Medical Record Number

Patient Name

Addressograph or Label

CLINIC VISITS • OB GENETICS CLINIC • PRENATAL GENETIC SCREENING QUESTIONNAIRE

Patient name: _____ (first last) Partner's name: _____ (first last)

Date of birth: ___/___/___ (mm dd yy) Occupation: _____ Date of birth: ___/___/___ (mm dd yy) Occupation: _____

Family and Patient Histories

1. Have you, your partner or anyone in either of your families had any of the following disorders?

a. Down syndrome	❑ No ❑ Yes	h. Tay Sachs/ Canavan disease	❑ No ❑ Yes
b. Other chromosome abnormality	❑ No ❑ Yes	i. Neurofibromatosis	❑ No ❑ Yes
c. Neural tube defect (spina bifida, anencephaly)	❑ No ❑ Yes	j. Muscular dystrophy	❑ No ❑ Yes
		k. Other nerve/muscle disorder	❑ No ❑ Yes
d. Bleeding disorder (hemophilia)	❑ No ❑ Yes	l. Bone or skeletal disease (dwarfism)	❑ No ❑ Yes
e. Cystic fibrosis	❑ No ❑ Yes		
f. Sickle cell disease	❑ No ❑ Yes	m. Polycystic kidney disease	❑ No ❑ Yes
g. Thalassemia	❑ No ❑ Yes	n. Heart defect at birth	❑ No ❑ Yes
		o. Cleft lip / palate	❑ No ❑ Yes

2. Are you and your partner related by blood; for example, cousins?..... ❑ No ❑ Yes
3. Do you, your partner, or a close relative (your biological child, your mother or father, your sister or brother, aunt, uncle or grandparent) have any of the following:
   a. Mental retardation? ..... ❑ No ❑ Yes
      Indicate the cause, if known: _____
   b. Genetic condition or chromosome abnormality not listed above? ..... ❑ No ❑ Yes
   c. Birth defect not listed above? ..... ❑ No ❑ Yes
   d. Serious medical problem that you are concerned about? ..... ❑ No ❑ Yes

Reproductive History

4. Have you or your partner had any of the following:
   a. A baby who died at birth, shortly after birth or within the first year? ..... ❑ No ❑ Yes
   b. 2 or more *unexplained* miscarriages in the 1st trimester? ..... ❑ No ❑ Yes

Current Pregnancy (if applicable)

Have you had any of the following:

5. Prenatal ultrasound? ..... ❑ No ❑ Yes
6. Reproductive technology or assistance (IUI, IVF, ICSI, PGD, donor)? ..... ❑ No ❑ Yes
7. Medications, street drugs, or alcohol since your last menstrual period (excluding prenatal vitamins)?..... ❑ No ❑ Yes
8. Diabetes (gestational, type 1 or 2)? ..... ❑ No ❑ Yes
9. Nuchal translucency (NT) or Expanded AFP screening test?..... ❑ No ❑ Yes

If YES to any questions above, please explain: _____

_____ _____
SIGNATURE (Patient, Parent or Properly Designated Representative) Date

_____
RELATIONSHIP to Patient

DATE: TIME:	Genetic Counselor Signature:
	PRINT Name: