Cheyenne Women's Clinic, PC

Genetics Questionnaire

Name:____________________________ Date:

Total pregnancies: ___
Full term: ___
Premature: ___
Spontaneous or therapeutic abortions: ___
Stillbirths: ___
Ectopic pregnancies: ___
Multiple births: ___
Living: ___
Dates and type of deliveries: (eg. 1992 vaginal, 2005 CS)

Will you be 35 or older at the time of delivery? Yes No
Will the baby's father be 50 or older at the time of delivery? Yes No
Have you ever been sensitized a blood antibody Yes No
Have you ever received blood? Yes No
Have you ever had surgery on the uterus or cervix (LEEP or Cone biopsy)? Yes No
Have you ever had trouble with the birth of a baby? Yes No
Have you ever been exposed to DES (diethyl stilbestrol)? Yes No
Do you or the baby's father have a birth defect or a chromosomal abnormality? Yes No
Detail-
In any previous relationship have you or the baby's father had a child with a birth defect born either alive or dead? Yes No
Detail-
Do you or the baby's father have a family history of any birth defects, familial problems or chromosomal problems? Yes No
Detail-
Do you or the baby's father have any relatives with a history of mental retardation? Yes No
Do you or the baby's father have any relatives with autism? Yes No
Have you or the baby's father ever had a still birth of a child? Yes No
Have you or the baby's father ever had a history of more than 2 miscarriages? Yes No
Have you or the baby's father ever had a chromosomal study? Yes No
Are either you or the baby's father of Eastern European or Jewish ancestry? Yes No
If yes would you like to be screened for:
Tay-Sachs
Canavan Disease
Cystic Fibrosis
Familial Dysautonomia
Fanconi anemia
Nieman-Pick disease
Mucolipidosis
Bloom syndrome
Guacher disease
Are either you or the baby's father of French or Cajun ancestry? Yes No
If yes would you like ot be screened for any of the following-
Tay Sachs
Cystic Fibrosis
Are you or the baby's father of Italian, Greek or Mediterranean ancestry? Yes No
If yes would you like ot be screened for any of the following diseases-
Cystic Fibrosis
Thalessemia
Sickle Cell Disease
Any history of any of the following? Yes No
Bloom Syndrome
Gaucher disease
Neurofibromatosis
Huntington's Chorea or movement disorders
Any bleeding disorder
Fragile X syndrome
Would you like to speak to a genetic counselor about any of the above or other diseases or problems? Yes No
Are there other personal genetic or familial diseases or family history of any problems that you would like to discuss? Yes No