Washington University in St. Louis Physicians

Welcome!

Department of Obstetrics and Gynecology
Division of Ultrasound and Genetics
Prenatal/Preconceptual Counseling Questionnaire

FEMALE PARTNER

Name _____ Date of Birth _____ Age _____

How many times have you been pregnant? _____

How many living children do you have? _____

Have you ever had an elective abortion? ☐ Yes ☐ No

a. If yes, please indicate what year(s) and approximate stage of pregnancy _____

b. If yes, for what reason? ☐ Medical ☐ Personal

Have you ever had a miscarriage? ☐ Yes ☐ No If yes, how many _____

Have you ever had a stillborn baby or a baby who died within a month after birth? ☐ Yes ☐ No

If yes, please indicate year, sex of baby, and cause of death _____

How old were you at the time of your first period? _____

Are your menstrual periods:

☐ Regular, every 28 – 31 days ☐ Regular, less than 28 days apart

☐ Regular, more than 31 days apart ☐ Irregular

Do you have any major or chronic medical conditions (i.e., asthma, hypertension, diabetes, cancer, etc.)? ☐ Yes ☐ No If yes:

Condition	Date of Diagnosis	Condition	Date of Diagnosis

Please list any medications taken on a regular basis and specify approximate dosage:

Medication	Approximate Dose	Medication	Approximate Dose

What is your occupation? _____

Are you exposed to radiation or toxic substances on any basis? ☐ Yes ☐ No

If yes, please indicate the type and amount of exposure _____

_____

Have you had any alcohol or recreational drug exposure during this pregnancy? ☐ Yes ☐ No

MALE PARTNER

Name _____ Date of Birth _____ Age _____

How many living children do you have (include children by previous unions)? _____

Have you ever fathered a child with a birth defect or genetic disease? ☐ Yes ☐ No

If yes, please describe the condition and status of the child _____

_____

Do you have any chronic medical conditions (i.e., asthma, hypertension, diabetes, etc.)? ☐ Yes ☐ No If yes:

Condition	Date of Diagnosis	Condition	Date of Diagnosis

Please list any medications taken on a regular basis and specify approximate dosage:

Medication	Approximate Dose	Medication	Approximate Dose

What is your occupation? _____

Are you exposed to radiation or toxic substances on any basis? ☐ Yes ☐ No

If yes, please indicate the type and amount of exposure _____

_____

CONSANGUINITY

Are the two of you related in any way other than marriage (e.g., first cousins, uncle and niece)? ☐ Yes ☐ No

If yes, please describe the relationship _____

Where did your family come from originally (e.g., England, Italy, etc.)?

Female partner _____

Male partner _____

Patient Questionnaire

Are You at Increased Risk to Carry a Genetic Disorder for which Carrier Testing is Available?

Each of us carry at least 6 disease genes, which, if inherited in a double dose, can cause a disease. In the absence of a family history, the only clue to which disorders we might be carrying is knowing our ancestry or ethnic background. In many cases, genetic testing by a blood test can be done to determine if a woman and/or her partner is a carrier for these disorders. If you would like to know if you or your partner is at increased risk to carry any of these diseases, look through the list below and check any and all boxes that match your ancestry or ethnic background (include your Parents and Grandparents, if known).

MOTHER OF BABY

- ☐ Northern European (England, Ireland, etc.)
- ☐ Asian Indian
- ☐ Ashkenazi Jewish
- ☐ African American
- ☐ Latino/Hispanic
- ☐ French Canadian
- ☐ Italian
- ☐ Greek
- ☐ Mediterranean
- ☐ Middle Eastern
- ☐ Asian
- ☐ Caribbean

FATHER OF BABY

- ☐ Northern European (England, Ireland, etc.)
- ☐ Asian Indian
- ☐ Ashkenazi Jewish
- ☐ African American
- ☐ Latino/Hispanic
- ☐ French Canadian
- ☐ Italian
- ☐ Greek
- ☐ Mediterranean
- ☐ Middle Eastern
- ☐ Asian
- ☐ Caribbean

You may also be a carrier if you or your partner have a family history of any of the following diseases:

- ☐ Cystic Fibrosis
- ☐ Sickle Cell Disease
- ☐ Alpha Thalassemia
- ☐ Beta Thalassemia
- ☐ Tay-Sachs Disease
- ☐ Canavan Disease
- ☐ Familial Dysautonomia

Have you or your partner had genetic carrier screening for CF, Sickle Cell, Thalassemia, Tay Sachs or any other genetic conditions? ☐ Yes ☐ No

If yes,

Conditon Tested For	Result
_____	_____
_____	_____
_____	_____

Please give this form to the genetic counselor. She will review your information, and identify those genetic disorders which you are at increased risk to carry. She can also provide you with specific information about how we inherit and pass on our genetic material AND a description of the disorder(s) you are at increased risk to carry. If you and/or your partner would like to be tested, please contact your physician or healthcare provider's office.

Prenatal Genetic Screening Questionnaire

Patient's Name _____ Date of Birth _____

The following questions will enable us to determine whether certain tests may be appropriate in helping to evaluate the health of your unborn baby. Please complete this questionnaire and bring it with you at the time of your appointment. All information will be kept confidential.

This questionnaire is designed to identify potential genetic issues that have immediate relevancy to fetal health. If you have particular concerns about other conditions in your family (cancer, heart disease, diabetes, etc.), please make the genetic counselor aware of your concerns.

1. Have you OR the baby's father had any children (living or dead) with a birth defect, intellectual disability or serious health problem (include any children from you and/or your partner's previous relationships/marriages)? . . . . . ☐ Yes ☐ No

   If yes, please explain _____

2. Were you OR the baby's father born with any birth defects (congenital heart defect, cleft palate, etc.) or do either of you have any serious health problems? . . . . . ☐ Yes ☐ No

   If yes, please explain _____

3. Does/did anyone in either your or the baby's father's family have any of the following?

   Please include yourself, the baby's father, your children, your parents, brothers, sisters, nieces, nephews, aunts, uncles, and grandparents.

   Intellectual disability, learning disability, or autism? . . . . . ☐ Yes ☐ No

   Down syndrome or other chromosome abnormality? . . . . . ☐ Yes ☐ No

   Born with a heart defect? . . . . . ☐ Yes ☐ No

   Born with cleft lip or palate? . . . . . ☐ Yes ☐ No

   Born with a neural tube defect (open spine, spina bifida or anencephaly)? . . . . . ☐ Yes ☐ No

   Born with extra/missing fingers or toes or abnormality of arms, legs, hands or feet? . . . . ☐ Yes ☐ No

   Hearing problems or deafness (before age 60)? . . . . . ☐ Yes ☐ No

   Serious eye problems or blindness? . . . . . ☐ Yes ☐ No

   Hemophilia or a bleeding disorder? . . . . . ☐ Yes ☐ No

   Neuromuscular disease or muscular dystrophy? . . . . . ☐ Yes ☐ No

   Huntington disease? . . . . . ☐ Yes ☐ No

   Three or more miscarriages and/or stillbirths? . . . . . ☐ Yes ☐ No

   Seizures or epilepsy? . . . . . ☐ Yes ☐ No

4. Do you, the baby's father, or anyone in either of your families have a birth defect, inherited disorder, or chromosome abnormality not listed above? . . . . . ☐ Yes ☐ No

   If yes, indicate condition(s) and person(s) affected _____

5. Have you taken any medications, including alcohol or recreational drugs, or had any X-rays since your last menstrual period? . . . . . ☐ Yes ☐ No

   If yes, please list and the dates taken _____

6. Do you or the baby's father have concerns about any other conditions in either of your families? . . . . . ☐ Yes ☐ No

   If yes, please explain _____