North Austin Maternal Fetal Medicine

FAMILY HISTORY AND GENETIC SCREENING

Name:_____ **LMP** _____ **or EDC** _____

Your Date of birth _____

Your age at the baby's due date:____ years. The baby's father's age at the due date: ____years.

Chronic medical problems: _____

Current medications: _____

Previous surgeries:_____

Number of previous cesarean sections:_____ Medication Allergies:_____

Family and Patient History

Some genetic problems occur more in couples with certain racial or genetic backgrounds. Does your family or the father of the baby's family have the following ethnic background:

Yes	No	
☐	☐	Southeast Asia, Taiwan, China, or the Philippines
☐	☐	Italy, Greece, or the Middle East

If yes, have you or your partner been tested for thalassemia? Yes☐ No☐

Yes	No	
☐	☐	Eastern European (Ashkenazi) Jewish
☐	☐	French Canadian, Acadian

If yes, have you or your partner been tested for Tay Sachs? Yes☐ No☐

Yes	No	
☐	☐	African American, African, or Black

If yes, have you or your partner been tested for sickle cell anemia? Yes☐ No☐

During this pregnancy, have you

Smoked cigarettes?	Yes	No	_____
Drank alcoholic beverages?	Yes	No	_____
Used recreational drugs?	Yes	No	_____

Please complete and sign the back of this page

Have you, the baby's father, or anyone in either of your families ever had any of the following?
If "yes", please explain in the space provided:

Yes	No	
○	○	Down Syndrome_____
○	○	Other Chromosome Abnormalities_____
○	○	Neural Tube Defect (e.g. spina bifida, anencephaly)_____
○	○	Hemophilia or Other Bleeding Disorders_____
○	○	Cystic Fibrosis_____
○	○	Sickle Cell Anemia_____
○	○	Thalassemia (Mediterranean anemia)_____
○	○	Tay Sach's Disease_____
○	○	Muscular Dystrophy_____
○	○	Neurofibromatosis_____
○	○	Huntington's Disease_____
○	○	Other Nerve, Muscle or Seizure Disorder (e.g. epilepsy)_____
○	○	Phenylketonuria (PKU)_____
○	○	Kidney Disease_____
○	○	Heart Defect (from birth)_____
○	○	Cleft Lip and/or Cleft Palate_____
○	○	Limb Defects (extra or missing digits, malformed arms, legs, hands or feet)_____
○	○	Deafness / Early Onset Hearing Loss_____
○	○	Blindness / Early Onset Vision Loss_____
○	○	Do you or the baby's father have any relatives with mental retardation or developmental delay?_____
○	○	Does anyone in either of your families have a genetic defect, or chromosome abnormality not listed above?_____
○	○	Have you or the baby's father had a baby that died shortly after birth or in the first year?_____
○	○	Have you or the baby's father had a stillborn child, or three or more first trimester miscarriages?_____
○	○	Are you and the baby's father blood-related in any way (i.e., cousins, uncle-niece, etc.)?_____
○	○	Is there any other family history that you have concerns about?_____

My signature below indicates that the above family and pregnancy history information provided is complete and correct.

Signature of person completing form *Today's date*