Prenatal Diagnosis Screening Questions

Patient Name: ____________________________________________ Date: __________________________

1. Will you be age 35 or older when the baby is due? Yes ___ No ___

2. Have you or the baby’s father or anyone in either of your families ever had:
   a. Down syndrome? Yes ___ No ___
   b. Spina bifida or meningomyelocele? Yes ___ No ___
   c. Hemophilia? Yes ___ No ___
   d. Muscular dystrophy? Yes ___ No ___
   e. Cystic fibrosis Yes ___ No ___
   f. Thalassemia Yes ___ No ___

3. Have you or the baby’s father had a child born dead or alive with a birth defect not listed in question #2 above? Yes ___ No ___

4. Do you or the baby’s father or close relative in either of your families have any inherited genetic or chromosomal disease or disorder not listed above? Yes ___ No ___

5. Have you ever had a pregnancy which ended in stillbirth or had two or more spontaneous losses (miscarriage)? Yes ___ No ___

6. Have you ever delivered a baby prematurely, before 36 weeks? Yes ___ No ___

7. Have you or the baby’s father ever had genital herpes? Yes ___ No ___

8. Is there a chance that you or the baby’s father have been exposed to the AIDS virus? Yes ___ No ___

9. Do you or the baby’s father have any close relatives descended from Jewish people who lived in Eastern Europe (Ashkenazi Jews)? Yes ___ No ___
   If yes, have either you or the baby’s father been screened for Tay-Sachs disease? Yes ___ No ___

10. Are you or have you ever been on a special diet, e.g. for PKU or strict vegetarian? Yes ___ No ___
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11. Are you or the baby’s father black or Hispanic?  
   Yes ___ No ___

   Have you been screened for sickle cell trait?
   Yes ___ No ___

   What was the result? Positive ___ Negative ___
   Yes ___ No ___

   Has the father of the baby been screened for sickle cell trait?
   What was the result: Positive ___ Negative ___
   Yes ___ No ___

12. Are you a Jehovah’s Witness or do you have any other beliefs, 
   religious or otherwise, that prevent you from receiving 
   blood products?  
   Yes ___ No ___

13. Do you smoke?  
   If yes, how much? ___
   Yes ___ No ___

14. Do you drink alcohol?  
   If yes, how much? ___
   Yes ___ No ___

15. Do you use street drugs?  
   Yes ___ No ___

   Have you used street drugs in the past?  
   Yes ___ No ___

   Which ones? ________________________
   Yes ___ No ___

16. Are you allergic to penicillin?  
   Yes ___ No ___

17. Have you ever been physically, sexually or mentally abused?  
   Yes ___ No ___

   Would you like to discuss this with a physician?  
   Yes ___ No ___

Patient’s Signature: ___________________________ Date: __________

Physician’s Signature: __________________________________________________________________________

Physicians Notes: _____________________________________________________________________________