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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 ___

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

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 or the baby's father smoke? Yes ___ No ___
If yes, how much? ____
The baby's father? ____

14. Do you or the baby's father drink alcohol? Yes ___ No ___
If yes, how much? ___
The baby's father? ___

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

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

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 Name: ____

Patient's Signature: ____ Date: ________________

Physician's Signature: ____

Physicians Notes: ____