



THE WOMEN'S HEALTHCARE GROUP
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PRENATAL GENETIC SCREENING

The following information is very important to your health. Please take the time to fully and completely fill out this important information. We are counting on you!

Patient Name: _____

Date: _____

GENETIC SCREENING/TERATOLOGY COUNSELING
(includes patient, baby's father or anyone in either family with:)

	Yes	No	<u>Notes</u>
1. Patient's age greater than or equal to 35 years as of estimated date of delivery <i>If you answered Yes to Question 1, we recommend high risk counseling to help you decide on any further testing, such as blood tests, ultrasound, or amniocentesis</i> <input type="checkbox"/> I understand this appointment will be scheduled for me <input type="checkbox"/> I decline high risk counseling; therefore, I will not be able to schedule the 1 st trimester screen, ultrasound at 18-20 weeks, CVS or amniocentesis <hr/> Signature of Patient			
2. Thalassemia (Italian, Greek, Mediterranean or Asian background): MCV < 80			
3. Neural Tube Defect (meningomyelocele, spina bifida or anencephaly)			
4. Congenital Heart Defect			
5. Down Syndrome			
6. Tay-sachs (e.g. Jewish, Cajun, French Canadian)			
7. Canavan Disease			
8. Sickle Cell Disease or trait			
9. Hemophilia or other blood disorders			
10. Muscular Dystrophy			
11. Cystic Fibrosis			
12. Huntington's Chorea			
13. Mental Retardation/Autism if Yes, was person tested for Fragile X?			
14. Other inherited genetic or chromosomal disorder			
15. Maternal Metabolic disorder (e.g. Type 1 Diabetes, PKU)			
16. Patient or baby's father had a child with birth defects not listed above			
17. Recurrent pregnancy loss or greater than 2 stillbirths			
18. Tumors in infants			
19. Medications (including supplements, vitamins, herbs or OTC drugs)/illicit/recreational drugs/alcohol since last menstrual period if Yes, agent(s) and strength/dosage			
20. Any other			

Do any of these apply to you?

_____ Treatment of sexually transmitted diseases

_____ GC Gonorrhea

_____ Chlamydia

_____ HPV, Human Papillomavirus, genital warts

_____ Hepatitis A/B/C

_____ Herpes

_____ Syphilis

_____ AIDS

_____ Multiple sexual partners (5 or more lifetime)

_____ Previous sexual partners have been bisexual,
abused IV drugs, have hemophilia, or positive for AIDS virus

_____ Healthcare worker

_____ IV Drug abuse

Have you ever used alcohol in the past? _____ Yes _____ No

If Yes, how many drinks per day? _____ per week? _____ per month? _____

When was your last use? _____

Have you ever used various drugs in the past, such as marijuana, heroin, cocaine, crack or other
drugs? _____ Yes _____ No

If Yes, what drug and route? _____

When was your last use? _____

Have you used any alcohol or other drugs during this pregnancy? _____ Yes _____ No

If Yes, please specify: _____

Have you had Chicken Pox? _____ Yes _____ No

Have you experienced postpartum depression? _____ Yes _____ No

Have you had a previous premature labor and/or delivery? _____ Yes _____ No

* My signature indicates that the above information is true and correct to the best of my belief.

***Patient Signature**

Date

Physician Signature

Date

FOR USE ON 1ST OFFICE VISIT ONLY - for patients less than Age 35 at delivery

Check the following statements that apply to you:

I have been informed of the availability of the first trimester screening (free Beta, PAPP-A, and nuchal translucency).

- I am interested in first trimester screening and have received the information and telephone number for Maternal Fetal Medicine.
- I am not interested in first trimester screening.

Patient Signature

Date

FOR USE ON 2ND OFFICE VISIT ONLY - for ALL patients

Check the following statements that apply to you:

- I have read and understand the information on the Quad Screen.
- I choose to have the Quad Screen.
- I do not want the Quad Screen.

Patient Signature

Date