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	Notes
1.Patient's age greater than or equal to 35 years as of estimated date of delivery, **or** The father of the baby's age is greater or equal to 45 years as of the estimated date of delivery. *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 understand this appointment will be scheduled for me ❑ I decline high risk counseling; therefore, I will not be able to schedule CVS or amniocentesis _____ **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. Jewish Ancestry, if yes ❑ Family history of Tay-Sachs, Canavan, cystic fibrosis, or familial dysautonomia ❑ I consent to screening for Tay-Sachs, Canavan, cystic fibrosis, and familial dysautonomia			
7. Cajun or French Canadian Ancestry, if yes ❑ Family history of Tay-Sachs ❑ I consent to screening for Tay-Sachs			
8. Sickle Cell Disease or trait			
9. Hemophilia or other blood disorders			
10. Muscular Dystrophy			
11. Cystic Fibrosis			
12. Mental Retardation/Autism if Yes, was person tested for Fragile X?			
13. Other inherited genetic or chromosomal disorder			
14. Maternal Metabolic disorder (e.g. Type 1 Diabetes, PKU)			

15. Patient or baby's father had a child with birth defects not listed above			
16. Recurrent pregnancy loss or greater than 2 stillbirths			
17. Tumors in infants			
18. Medications (including supplements, vitamins, herbs or OTC drugs)/ illicit/recreational drugs/alcohol since last menstrual period if Yes, agent(s) and strength/dosage			
19. Any dietary restrictions or special diets			
20. Any others:			

Do any of these apply to you?

_____ Treatment of sexually transmitted diseases

_____ GC Gonorrhea
_____ Chlamydia
_____ HPV, Human Papilloma virus, 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

****Routine Cultures for Gonorrhea/Chlamydia will be done at your first prenatal visit****

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 had a history of MRSA? _____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**