

OB/GYN ASSOCIATES OF CHICO GENETIC QUESTIONNAIRE

Patient Name: _____ Date: _____

Please answer these questions to help us determine whether to recommend further testing.

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| 1. Will you be age 35 or older when the baby is due? | YES | NO |
| 2. Will the baby's father be age 45 or older when the baby is due? | YES | NO |
| 3. Have you, or the baby's father, or your relatives had a child with a birth defect? Down Syndrome? Any chromosomal abnormality? | YES | NO |
| 4. Do you or the baby's father have a birth defect? | YES | NO |
| 5. Are there any family members with cystic fibrosis, hemophilia, muscular dystrophy, mental retardation, hydrocephalus etc.? | YES | NO |
| 6. Have you been tested for sickle cell traits, cystic fibrosis, Tay Sachs, Gaucher disease, or Thalassemia? | YES | NO |
| 7. Are there any familial diseases? | YES | NO |
| 8. Are you and the baby's father first cousins or related? | YES | NO |
| 9. Are you or your husband of African-American or Jewish heritage? | YES | NO |
| 10. Have you had German Measles (Rubella), or Chicken Pox (Varicella)? Any other diseases? | YES | NO |
| 11. Have you taken any medicines, drugs, herbal medicines or over the counter drugs during this pregnancy? | YES | NO |
| 12. Have you smoked or used alcohol during this pregnancy? | YES | NO |
| 13. Have you taken any street drugs in this pregnancy? (Marijuana, Speed, Cocaine, Heroin, etc.) | YES | NO |
| 14. Do you want Cystic Fibrosis carrier testing? | YES | NO |
| 15. Are you interested in talking with a Genetic Counselor? | YES | NO |

Patient Signature: _____ Date: _____