

OB/GYN ASSOCIATES OF CHICO GENETIC QUESTIONNAIRE

Patient Name: _____ Date: _____

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

1. Will you be age 35 or older when the baby is due? YES NO
2. Will the father of the baby be age 45 years old or older YES NO
3. Do you, or the baby's father, or your relatives have a child with a birth defect? Down Syndrome? Any chromosomal abnormality? YES NO
4. Are there any family members with cystic fibrosis, hemophilia, muscular dystrophy, mental retardation, hydrocephalus etc.? Are there any familial diseases? YES NO
5. Have you been tested for sickle cell trait, cystic fibrosis, Tay Sachs, Gaucher disease, or Thalassemia? YES NO
6. Are there any diseases that run in your family or in the father of the baby's family. YES NO
7. Are you and the baby's father first cousins or related? YES NO
8. Are you or your husband of African-American or Jewish heritage? YES NO
9. Have you had German Measles (Rubella), or Chicken Pox (Varicella)? Any other diseases? YES NO
10. Have you taken any medicines, drugs, herbal medicines or over the counter drugs during this pregnancy? YES NO
11. Have you smoked or used alcohol during this pregnancy? Have you taken any street drugs in this pregnancy?(Marijuana, Speed, Cocain, Heroin, etc.) YES NO
12. Do you want Cystic Fibrosis carrier testing? YES NO
13. The American College of OB/GYN now suggest all patients be offered screening for chromosomal birth defects. Testing could be a 12 week sonography, AFP, Aminocentesis or Chorionic Villus Sampling. Are you interested? YES NO
14. Are you interested in talking with a Genetic Counselor? YES NO

Patient Signature: _____ Date: _____