

NAME: _____ DATE: _____

Please complete this form and bring it with you to your appointment. If you answer "yes" to the questions with an "*" (1, 2, 18), please call us at 612-863-4502 so a genetic counselor or doctor can best address your concerns. Feel free to add in any concerns you may have.

Pregnancy History

(Answer "yes" if the following statements are true since conception or last menstrual period. If known, please provide dates of medication, illness, x-ray or alcohol consumption.)

YES NO

- * 1. Have you taken any medications, drugs or herbal preparations? If yes, please list _____
- * 2. Have you had an illness or infection? If so, please describe _____
- 3. Have you ever had a fever higher than 101 degrees or taken a sauna or hot tub?
- 4. Have you had any x-rays or surgeries? If so, please describe _____
- 5. Did you get pregnant while using birth control pills or other contraception? _____
- 6. Do you smoke? If so, how many cigarettes or packs per day? _____
- 7. Have you consumed alcohol since your last period? If so, how much and how often? _____
- 8. Are there any other exposures that concern you? _____

Mother's and Father's Histories

- 9. Do either you or the baby's father have diabetes, epilepsy, kidney disease, cancer or any other chronic medical condition? _____
- 10. Have you ever been exposed to Rubella, cytomegalovirus or other infectious conditions? _____
- 11. Have you or the baby's father been treated for cancer? _____
- 12. Will you be 35 or older when the baby is born? _____
- 13. Will the father of the baby be over the age of 50 when the baby is born? _____
- 14. Do you or the baby's father have any common relatives? _____
- 15. What is your ancestry and the father of the baby's ancestry? Jewish African/African-American Asian
 Mediterranean Latin American French Canadian Northern European
 Other; please specify _____
- 16. Have you had a stillbirth or miscarriage? If so, how many? _____
- 17. Have you been treated for or do you have a history of infertility and/or was this pregnancy achieved with an assisted reproductive technology? If yes, please specify _____

Family History

- * 18. Do you or the baby's father:
 - a. have a birth defect, mental or physical disability, or other disorder that might be hereditary?
If so, please specify _____
 - b. have any children (living or deceased) who have/had birth defects, mental retardation, learning disability, physical disability, chronic illness or known genetic condition?
If so, please specify _____
 - c. have brothers, sisters, uncles, aunts, nieces, nephews, cousins, grandparents or more distant relatives with birth defects, mental or physical disabilities or known genetic disorders (i.e. cystic fibrosis, muscular dystrophy, etc.)?
If so, please specify _____

Patient signature _____

Genetic counselor signature _____

