Genetic Screening Questionnaire

Please fill out this questionnaire before your appointment at Minnesota Perinatal Physicians.

Minnesota Perinatal Physicians

PATIENT NAME		TODAY'S DATE	PATIENT MRN#
REFERRING PROVIDER		NAME OF THE BABY'S FATHER	
OCCUPATION	BIRTHDATE	OCCUPATION	BIRTHDATE

These questions are about you and your family.

Please indicate race/nationality or ethnic group:

African-American ____ Northern European ____ Jewish____

Native American____ Asian____ Pacific Islander ____

Mediterranean (Greek/Italian) ____ Hispanic/Latin American ____

French-Canadian ____ Middle Eastern ____

These questions are about the father of the baby and his family.

Please indicate race/nationality or ethnic group:

African-American ____ Northern European ____ Jewish____

Native American____ Asian____ Pacific Islander ____

Mediterranean (Greek/Italian) ____ Hispanic/Latin American ____

French-Canadian ____ Middle Eastern ____

Do you or members of your family have any of the following conditions?

	No	Yes	(Specify Relative)
Cleft Lip or Palate	☐	☐	_____
Heart Defects	☐	☐	_____
Spina Bifida (Open Spine)	☐	☐	_____
Muscle Disease/ Muscular Dystrophy	☐	☐	_____
Down syndrome	☐	☐	_____
Learning Problems (mental retardation, autism, learning disability)	☐	☐	_____
Vision or hearing loss from birth	☐	☐	_____
Cystic Fibrosis	☐	☐	_____
Kidney Disease	☐	☐	_____
Blood Disorders (Sickle Cell, Hemophilia, Thalassemia)	☐	☐	_____
Other: _____	☐	☐	_____

Does the father of the baby or any members of his family have any of the following conditions?

	No	Yes	(Specify Relative)
Cleft Lip or Palate	☐	☐	_____
Heart Defects	☐	☐	_____
Spina Bifida (Open Spine)	☐	☐	_____
Muscle Disease/ Muscular Dystrophy	☐	☐	_____
Down syndrome	☐	☐	_____
Learning Problems (mental retardation, autism, learning disability)	☐	☐	_____
Vision or hearing loss from birth	☐	☐	_____
Cystic Fibrosis	☐	☐	_____
Kidney Disease	☐	☐	_____
Blood Disorders (Sickle Cell, Hemophilia, Thalassemia)	☐	☐	_____
Other: _____	☐	☐	_____

Have you had more than one miscarriage? ☐ No ☐ Yes

If "yes," how many? _____

Have you ever had a stillborn baby after the fifth month of pregnancy? ☐ No ☐ Yes

If "yes," explain: _____

Have you ever had a child die before one year of age? ☐ No ☐ Yes

If "yes," explain_____

Have you ever had a child with a birth defect? ☐ No ☐ Yes

If "yes," explain: _____

_____

Are you and the father of the baby blood relatives? (such as cousins) ☐ No ☐ Yes

If "yes," how are you related?_____

Do you have diabetes? ☐ No ☐ Yes

Do you have epilepsy or seizures? ☐ No ☐ Yes

Have you taken medicine during the pregnancy? ☐ No ☐ Yes

If "yes," which medicines have you taken, when did you take them, and how much? _____

_____

_____

At any time during this pregnancy, have you:

had any alcohol? ☐ No ☐ Yes

smoked cigarettes? ☐ No ☐ Yes

used recreational drugs? (such as marijuana, cocaine, meth, etc.) ☐ No ☐ Yes

If "yes," describe when used and how much. _____

_____

Are you exposed to any chemicals at work or at home? ☐ No ☐ Yes

If "yes," explain:_____

Have you had any illnesses or high fevers during the pregnancy? ☐ No ☐ Yes

If "yes," explain:_____

Have you been exposed to X-rays or radiation during the pregnancy? ☐ No ☐ Yes

If "yes," explain:_____

During this pregnancy, have you handled cat litter? ☐ No ☐ Yes

Reviewed By: _____ Date: _____