Genetic Screening Questionnaire

Please fill out this questionnaire before your appointment at Minnesota Perinatal Physicians.
*Biological mother is defined as a person assigned female at birth.
**Biological father is defined as a person assigned male at birth.

PATIENT NAME		PARTNER NAME	
PATIENT PRONOUNS She/Her He/Him They/Them Other (please list): ________		PARTNER PRONOUNS She/Her He/Him They/Them Other (please list): ________	
OCCUPATION	BIRTHDATE	OCCUPATION	BIRTHDATE

This question is about the biological mother* of the pregnancy and their family, or the egg donor.
(Please mark all that apply because some genetic conditions are more common in certain ethnic groups.)

African/African American (Black) ☐ European (White) ☐
Spanish/Hispanic/Latino ☐ SE Asian/Taiwanese/Chinese/Filipino ☐
Italian/Greek/Middle Eastern/Indian Subcontinent ☐ Native American ☐
French-Canadian/Cajun ☐ Jewish ☐ Other: ____________

This question is about the biological father of the pregnancy and their family, or the sperm donor.**
(Please mark all that apply because some genetic conditions are more common in certain ethnic groups.)

African/African American (Black) ☐ European (White) ☐
Spanish/Hispanic/Latino ☐ SE Asian/Taiwanese/Chinese/Filipino ☐
Italian/Greek/Middle Eastern/Indian Subcontinent ☐ Native American ☐
French-Canadian/Cajun ☐ Jewish ☐ Other: ____________

Have the biological mother of the pregnancy, the biological father of the pregnancy, the egg donor, the sperm donor, or any of their family members had any of the following conditions?

	YES	NO	Specify Whom
Heart defects (at birth)	☐	☐	________
Cleft lip or palate	☐	☐	________
Neural tube defects (Open spine, spina bifida, anencephaly)	☐	☐	________
Nerve or muscle diseases (Neurofibromatosis, muscular dystrophy, Huntington's)	☐	☐	________
Vision or hearing loss from birth	☐	☐	________
Learning Problems (Intellectual disability, autism, learning disability)	☐	☐	________
Chromosome conditions (Down syndrome, 22q11.2 deletion, Turner syndrome)	☐	☐	________
Blood disorders (Sickle cell, hemophilia, thalassemia)	☐	☐	________
Bone or skeletal diseases (Achondroplasia, dwarfism, osteogenesis imperfecta)	☐	☐	________
Other: ________ ________	☐	☐	________

Have you had a stillbirth or a miscarriage? ☐ Yes ☐ No

If "yes", explain: ____________

Have you ever had a child die in childhood? ☐ Yes ☐ No

If "yes", explain: ____________

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

If "yes", explain: ____________

Are the biological mother and father of the pregnancy blood relatives? ☐ Yes ☐ No
(such as cousins)
If "yes", what is the relation? ____________

Have you, the egg donor, the biological father or the sperm donor had any genetic tests? ☐ Yes ☐ No
(such as chromosomes, cystic fibrosis, sickle cell, carrier screening)

If "yes", please specify: ____________

Allina Health

MINNESOTA PERINATAL PHYSICIANS
GENETIC QUESTIONNAIRE

PATIENT LABEL

59-01
Questionnaire

SR-15143 (01/22)

Was this pregnancy achieved through in vitro fertilization or other reproductive technology? ☐ Yes ☐ No

If “yes”, please specify if the following was used: ☐ donor sperm ☐ donor egg ☐ donor embryo ☐ surrogate

If “yes”, please specify the age at time of egg retrivial: _________

If “yes”, was genetic screening performed on the embryo(s)? ☐ Yes ☐ No

Excluding vitamins and iron, have you taken medicine during the pregnancy? ☐ Yes ☐ No

If “yes”, which medicines have you taken, when did you take them, and how much? ______________________________________

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Do you have questions on the risks of the use of tobacco, alcohol or recreational drugs (marijuana, cocaine, meth, etc.) during this pregnancy? ☐ Yes ☐ No

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

If “yes”, explain: ____

What additional questions or concerns do you have related to your family history, medical history, or exposures that may not have been addressed above?

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Reviewed by: ____ Date: __________________