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WALNUT HILL
Obstetrics & Gynecology Associates

PATIENT GENETIC SCREENING FORM

1. _____ _____ _____
Last Name of Patient First Maiden Home Phone Work Phone

_____ Any Chronic Medical Illness/Birth defects? Specify_____
Birth Date

_____

2. _____ _____ _____
Last Name of Father of this Pregnancy First Middle Home Phone Work Phone

_____ Any Chronic Medical Illness/Birth defects? Specify_____
Birth Date

_____

3. Are you related to the father of this pregnancy (i.e. first cousin)? Yes:____ No:____

4. Number of: Pregnancies_____ Voluntary Terminations_____ Spontaneous Abortions/Miscarriages_____ Livebirths_____

5. List any children (living and deceased) of both parents (include previous partners). If any of these children have medical illness, surgery, mental or developmental delays, specify in the column to the right.

Name(s) of Child(ren)	Age	Sex	Father's Name	Mother's Name	Specify

6. What is your ethnicity (i.e. the countries your ancestors are from)?_____ Your Partner?_____
If your ethnicity is included in the list below, you may be at risk for certain genetic diseases more commonly found in these groups. Based on your ethnicity, do you or your partner desire carrier testing for any of the following conditions? Please circle one.

Caucasian? (Cystic Fibrosis)	Yes ○	Decline Testing ◉	Mom previously tested, Result: N/A Dad previously tested, Result: N/A
Ashkenazi Jewish? (Tay-Sachs/Canavan Diseases)	Yes ○	Decline Testing ◉	Mom previously tested, Result: N/A Dad previously tested, Result: N/A
Cajun/French Canadian? (Tay-Sachs Disease)	Yes ○	Decline Testing ◉	Mom previously tested, Result: N/A Dad previously tested, Result: N/A
Black/East Indian? (Sickle Cell Disease)	Yes ○	Decline Testing ◉	Mom previously tested, Result: N/A Dad previously tested, Result: N/A

Mediterranean/Greek/Italian (β-thalassemia) Yes ○ Decline Testing ◉ Mom previously tested, Result: N/A
Dad previously tested, Result: N/A

Southeast Asian/Phillipino? (α-thalassemia) Yes ○ Decline Testing ◉ Mom previously tested, Result: N/A
Dad previously tested, Result: N/A

7. Check below if any of the following occurred in either the mother or the father of this pregnancy's families – grandparents, parents, children, sisters, brothers, and descendents (living or deceased).

Description	Specify Type and/or Cause, if known
1._____ Birth defects	
2._____ Infant or childhood deaths	
3._____ Multiple miscarriages (2 or more)	_____
4._____ Mental Retardation	
5._____ Muscular Dystrophy	_____
6._____ Early onset Blindness	
7._____ Early onset Deafness	_____
8._____ Dwarfism	
9._____ Hemophilia or Bleeding Disorder	_____

10._____ Down syndrome (mongolism)
11._____ Other chromosome abnormalities
12._____ Spina Bifida
13._____ Hydrocephalus (water on the brain)
14._____ Cleft Lip or Palate
15._____ Heart Defect at Birth
16._____ Early Onset Cancer (Under 35)
17._____ Early Onset Emphysema (Under 35)
18._____ Phenylketonuria (PKU)
19._____ Cystic fibrosis or Carrier
20._____ Tay-Sachs disease or Carrier
21._____ Thalassemia disease or Carrier
22._____ Fragile X Mental Retardation or Carrier
23._____ Polycystic Kidney Disease (PKD)
24._____ Any other inherited or genetic conditions not listed:_____

If you have checked ANY of the above, indicate which one(s) and your or the father of this pregnancy's relationship to the affected individual.

_____

_____

_____

In this pregnancy, have you had exposure to:

8. Medications or recreation drugs (include non-prescription drugs)? Yes:_____ No:_____
If yes, give names of the medication/drug, amount, and which weeks taken during the pregnancy:_____
_____

9. Alcohol? Yes:_____ No:_____ If yes, how much?_____

10. Tobacco? Yes:_____ No:_____ If yes, how much?_____

11. Infection, high fevers, or other illnesses? Yes:_____ No:_____
If yes, indicate type, duration, and which weeks during the pregnancy:_____
_____

12. Chemical/Pesticide/X-rays/Cat Litter Box? Yes:_____ No:_____
(Routine house extermination, lawn fertilization or dental x-rays are generally not a problem)
If yes, indicate type, duration, and which weeks during the pregnancy:_____
_____

Signature of Patient_____ Date_____