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PRENATAL DIAGNOSIS QUESTIONNAIRE

PATIENT NAME:_____ DOB: _____ Date of last period: _____

Birth defects (including mental retardation) occur in about one in every twenty pregnancies. Some couples have a greater than average risk of having a child with a birth defect. Your answers to the following questions will help us determine if you are at an **INCREASED** risk. If you are unsure about a specific question, please discuss it with us before answering.

1) Have you ever been pregnant? If yes, how many times? _____ _____yes _____no
2) Have you ever had a miscarriage? If yes, when? _____ _____yes _____no
3) Have you had a stillborn baby? _____yes _____no
4) Have any of your children died? _____yes _____no
5) If your baby's father has had children by another woman/other women, did she/they have miscarriages, stillbirths, children who died, children with birth defects or children who are mentally retarded? _____yes _____no
6) Will you be 35 or older when your baby is due? _____yes _____no
7) Are you and the baby's father related to each other? (1st cousins, 2nd cousins, etc) _____yes _____no
8) Have you or the baby's father (or any close relatives in either of your families) had Down's syndrome (mongolism), spina bifida (open spine), hemophilia, muscular dystrophy, cystic fibrosis, or mental retardation? _____yes _____no
9) Have you or the baby's father (or any close relatives in either of your families) had a child born dead or alive with a birth defect or genetic condition or inherited disorder not listed in question 7 above? _____yes _____no
10) Is there any condition, disease, disorder, or birth defect that is "genetic, inherited or runs" in your family or in the family of the baby's father? _____yes _____no
11) Are you or the baby's father from any of the following backgrounds: Jewish, Black, Asian, Mediterranean, (Greek, Italian, Turkish)? _____yes _____no
12) Have you or the baby's father been screened for any of the following disorders: Tay Sachs_____, Sickle Cell_____, Thalassaemia_____? _____yes _____no
13) Do you drink alcohol? _____yes _____no
14) Do you smoke? _____yes _____no
15) Since you became pregnant, have you taken **ANY** medications? (prescriptions or those bought without a prescription in any drug store or health food store) _____yes _____no
16) Since becoming pregnant, have you used Accutane or taken Vitamin A in high doses? _____yes _____no
17) Have you used any drugs (for example, cocaine, marijuana, crack, speed) either before or after becoming pregnant? If so please list:_____ _____yes _____no
18) Have you been on any special diets either before or during your pregnancy? _____yes _____no
19) Have you been exposed to x-rays or chemicals (at work or at home) during this pregnancy? _____yes _____no
20) Have you have a fever of 103 degrees or greater during the first two months of your pregnancy? _____yes _____no
21) Have you or the baby's father ever had Herpes? _____yes _____no
22) Have you ever had hepatitis? _____yes _____no
23) Do you have pets at home? If so, please list_____ _____yes _____no
24) Do you eat raw or uncooked meat? _____yes _____no
25) As part of your routine prenatal blood tests and in compliance with Texas House Bill #1345. Your blood will be screened for the HIV virus, unless you refuse this test. I refuse the HIV screen _____ (initial)

COMMENTS:_____

_____

_____

Date:_____ _____
PATIENT'S SIGNATURE