

REPRODUCTIVE GENETIC HISTORY QUESTIONNAIRE

Patient Name

Date

MEDICAL HISTORY:

YES	NO	DO YOU...	COMMENTS
<input type="checkbox"/>	<input type="checkbox"/>	1. Have diabetes?	_____
<input type="checkbox"/>	<input type="checkbox"/>	2. Have seizures or epilepsy?	_____
<input type="checkbox"/>	<input type="checkbox"/>	3. Have kidney disease?	_____
<input type="checkbox"/>	<input type="checkbox"/>	4. or your husband/partner have a history of cancer treatment?	_____
<input type="checkbox"/>	<input type="checkbox"/>	5. Have any skin disorders including moles, acne, light or dark patches of skin?	_____
<input type="checkbox"/>	<input type="checkbox"/>	6. Have rheumatoid arthritis or systemic lupus erythematosus (SLE)?	_____
<input type="checkbox"/>	<input type="checkbox"/>	7. Have a history of being on a special diet as a baby or small child? (You may need to ask your parents about this.)	_____
<input type="checkbox"/>	<input type="checkbox"/>	8. Know the results of routine prenatal blood test for rubella (German measles) susceptibility and if yes, check below: <input type="checkbox"/> IMMUNE <input type="checkbox"/> SUSCEPTIBLE (NOT IMMUNE)	_____
<input type="checkbox"/>	<input type="checkbox"/>	9. Have any other medical condition not mentioned?	_____

FAMILY HISTORY:

YES	NO		COMMENTS
<input type="checkbox"/>	<input type="checkbox"/>	10. Are you 34 years old or older?	_____
<input type="checkbox"/>	<input type="checkbox"/>	11. Is your husband/partner 55 years old or older?	_____
<input type="checkbox"/>	<input type="checkbox"/>	12. Are you and your husband/partner blood relatives (e.g. cousins)?	_____
<input type="checkbox"/>	<input type="checkbox"/>	13. Are you or your husband/partner of <input type="checkbox"/> Jewish, <input type="checkbox"/> Black, <input type="checkbox"/> Mediterranean descent?	_____
<input type="checkbox"/>	<input type="checkbox"/>	14. Have you had a stillbirth or miscarriage?	_____
DO YOU OR YOUR HUSBAND/PARTNER...			
<input type="checkbox"/>	<input type="checkbox"/>	15. Have any birth defects, handicapping condition, or disorder that might be hereditary?	_____
<input type="checkbox"/>	<input type="checkbox"/>	16. Have any previous children with birth defects, handicaps, or genetic disease?	_____
<input type="checkbox"/>	<input type="checkbox"/>	17. Have any children who died (other than in an accident)?	_____
<input type="checkbox"/>	<input type="checkbox"/>	18. Have any relatives who have had a stillborn infant or multiple miscarriages?	_____
<input type="checkbox"/>	<input type="checkbox"/>	19. Have a brother, sister or parent with a handicap, birth defect or genetic disease?	_____
<input type="checkbox"/>	<input type="checkbox"/>	20. Have uncles, cousins, nieces, nephews, grandparents, or grandchildren with birth defects or genetic diseases?	_____
<input type="checkbox"/>	<input type="checkbox"/>	21. Know of any family member with mental retardation (even mild) or learning disabilities?	_____

SOME EXAMPLES OF BIRTH DEFECTS AND GENETIC DISEASE THAT MIGHT BE IN YOUR FAMILY

(Please check any of the following that might be in your family)

- | | |
|-------------------------------------------------------------|-------------------------------------------------------------------------------------------------|
| <input type="checkbox"/> Anencephaly (open skull) | <input type="checkbox"/> Malformations or birth defects |
| <input type="checkbox"/> Blindness or eye problem | <input type="checkbox"/> Mental illness |
| <input type="checkbox"/> Bone disorder | <input type="checkbox"/> Mental retardation |
| <input type="checkbox"/> Cerebral palsy | <input type="checkbox"/> Muscular dystrophy |
| <input type="checkbox"/> Chromosome abnormality | <input type="checkbox"/> Neurologic or degenerative disorder |
| <input type="checkbox"/> Cleft lip/palate | <input type="checkbox"/> Neurofibromatosis |
| <input type="checkbox"/> Cystic fibrosis | <input type="checkbox"/> Short stature (under 5 ft.) |
| <input type="checkbox"/> Deafness | <input type="checkbox"/> Sickle cell anemia |
| <input type="checkbox"/> Down syndrome (mongolism) | <input type="checkbox"/> Skeletal problems (i.e. easily broken bones or curvature of the spine) |
| <input type="checkbox"/> Epilepsy or seizures | <input type="checkbox"/> Skin disease (including dark or light patches of skin) |
| <input type="checkbox"/> Heart defect | <input type="checkbox"/> Spina bifida (open spine) |
| <input type="checkbox"/> Hemophilia (bleeding tendency) | <input type="checkbox"/> Tay-Sachs disease |
| <input type="checkbox"/> Hydrocephalus (water on the brain) | <input type="checkbox"/> Urinary tract abnormality |
| <input type="checkbox"/> Kidney disease | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Limb defects | |

MEDICATIONS / DRUG EXPOSURES

YES NO

22. Do you take any prescription drugs or over-the-counter medications?
If you are pregnant, have you taken any medications since your last period?
Examples: (please check those you have taken during this pregnancy)
- | | |
|---------------------------------------------------------------------------------|--------------------------------------------------------------|
| <input type="checkbox"/> Accutane (or other dermatological or acne medications) | <input type="checkbox"/> Male hormones |
| <input type="checkbox"/> Antibiotics | <input type="checkbox"/> Medications for epilepsy (seizures) |
| <input type="checkbox"/> Anticoagulants (blood thinners to prevent blood clots) | <input type="checkbox"/> Multi-vitamins |
| <input type="checkbox"/> Anti thyroid drugs | <input type="checkbox"/> Steroids |
| <input type="checkbox"/> Birth control pills | <input type="checkbox"/> Tranquilizers |
| <input type="checkbox"/> Chemotherapeutic drugs (anti-cancer drugs) | <input type="checkbox"/> Vitamin A supplements |
| <input type="checkbox"/> Diet pills | <input type="checkbox"/> Other high dose vitamins |
| <input type="checkbox"/> Female hormones | <input type="checkbox"/> Other _____ |

YES NO

23. Have you had any illness or infection recently or do you have any chronic disease not covered on the other side? Explain: _____
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24. Have you had frequent or high fevers or do you take saunas or hot whirlpool baths?
25. Have you recently had X-rays or surgery or are you planning to do so soon?
26. Are you exposed to anesthetic gases, lead, other heavy metals or radiation at work?
27. Have you been exposed to pesticides or potentially toxic chemicals at home or elsewhere?
28. Do you drink more than one glass of alcohol per week (including beer)?
29. Do you have a household cat or clean a litter box?
30. Do you eat raw or very rare meat?
31. Do you smoke? If yes, how many per day? _____
32. Do you use any other drugs or medications not previously listed?
33. Do you have any other questions or concerns regarding your ability to have a healthy baby?