

PUTNAM GYNECOLOGY & OBSTETRICS OF GREENWICH, P.C.

Name: _____ Date: _____

Address: _____ Last Menstrual Period: _____
(LMP)

Phone: Home _____ Work _____ Husband _____

PRENATAL DIAGNOSIS SCREENING QUESTION

Please answer these questions as best you can. If you are unsure of some answers today, you may wish to ask your family and add information at your next visit. At the end of these questions is a space for you to describe any yes answers.

1. Will you be 35 or older when the baby is due? Yes _____ No _____

2. How old is the baby's father? _____

3. Do you work outside of the home? Yes _____ No _____

If yes, your occupation _____

The baby's father's occupation _____

Please answer all of the following questions. Please think about all family members, including yourself, the baby's father, children from a previous marriage, brothers, sisters, nieces, nephews, aunts, uncles and cousins.

4. Have you or the baby's father or anyone in either of your families ever had:

a. Down syndrome (mongolism)? Yes _____ No _____

b. Spina bifida or myelomeningocele (open spine)? Yes _____ No _____

c. Hemophilia (bleeding problems)? Yes _____ No _____

d. Muscular Dystrophy (muscle weakness)? Yes _____ No _____

5. Have you or the baby's father had a liveborn or stillborn child with a birth defect not listed above? Yes _____ No _____

6. Do you or the baby's father have any close relative with mental retardation? Yes _____ No _____

7. Do you or the baby's father or a close relative in either of your families have an inherited genetic or chromosomal disorder not listed above? Yes _____ No _____

8. Have you, or the spouse of the baby's father in a previous marriage, had 3 or more miscarriages? Yes _____ No _____

9. Do you or the baby's father have any chronic medical condition (for example epilepsy, diabetes, thyroid disease)? Yes _____ No _____

10. Are you and the baby's father blood relatives (for example cousins)? Yes _____ No _____

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11. Do you or the baby's father have any close relatives descended from Jewish people who lived in Eastern Europe? Yes _____ No _____

If yes, have you or the baby's father been screened for Tay Sachs disease, and if so, what were the results?

12. If you or the baby's father are black, have you or the baby's father been screened for Sickle Cell Trait? Yes _____ No _____

If yes, what were the results? _____

13. If you or the baby's father are Greek/Italian: Have you or the baby's father been screened for Thalassemia Minor (Mediterranean anemia)? Yes _____ No _____

If yes, what were the results? _____

14. Do you have cats as household pets? Yes _____ No _____

15. During this pregnancy, have you been exposed to or taken:

- a. Medications? Yes _____ No _____
- b. Birth control pills? Yes _____ No _____
- c. X-rays? Yes _____ No _____
- d. Drugs? (Cocaine, crack, etc.) Yes _____ No _____
- e. 1 or more cocktails/wine on a daily basis? Yes _____ No _____
- f. Cigarettes? Yes _____ No _____
- g. Do you eat raw meat? Yes _____ No _____
- h. Other Yes _____ No _____

16. Do you have religious objections (Jehovah's Witness) to receiving blood or blood derivatives? Yes _____ No _____

17. Do you have any other concerns regarding this pregnancy? Yes _____ No _____

Please give questions number and description of any yes answer below:

Question Number Description
