FOR OB PATIENTS ONLY

PATIENT NAME:_____

DATE OF BIRTH:_____

PRENATAL GENETICS SCREEN (AGES 45 AND UNDER)
(PLEASE CIRCLE YES OR NO BELOW)

1. Will you be 35 years or older when your baby is due? YES NO
2. Have you; the baby's father, or anyone in either of your families ever had any of the following:

- Downs Syndrome (mongolism YES NO
- Chromosomal Abnormality YES NO
- Neural Tube Defect (spine bifida, anencephaly) YES NO
- Hemophilia YES NO
- Muscular Dystrophy YES NO
- Cystic Fibrosis YES NO
- Huntington's Chorea YES NO

If yes to any of the above please indicate the relationship to you or your baby's father:

_____

3. Did you or the baby's father have a birth defect? YES NO
4. In any previous pregnancy have you or the baby's father had a child born, dead or alive, with a birth deficit not listed in questions 2? YES NO
5. Do you or the baby's father have any close relatives with mental retardation? YES NO
6. In any previous pregnancies have you or the baby's father had a stillborn child or three or more first trimester miscarriages? YES NO
7. Are you or the baby's father of Jewish ancestry? YES NO
   If yes, have either of your been tested for Tay-Sachs YES NO
8. Are you of the baby's father African American? YES NO
   If yes, have been tested for sickle cell trait?
9. Are you or the baby's father of Italian, Greek, or Mediterranean background? YES NO
   If yes, have either of you been tested for B-thalassemia? YES NO
10. Are you or the baby's father Philippine or Southwest Asian ancestory? YES NO
    If yes, have either of you been tested for A-thalassemia? YES NO
11. Excluding iron and vitamins, have you take any medications or recreational drugs since being pregnant or since your last menstrual period? YES NO

_____ _____

Patient Signature Date

_____ _____

Physician Signature Date