Stanford HEALTH CARE

Los Olivos Women's Medical Group

Genetics Questionnaire

Name: _____ Date: _____

Partner's name: _____ His contact phone: _____

Frist day of last menses: _____ Due Date: _____ Weeks pregnant: _____

Number of Pregnancies: _____ Full Term Deliveries: _____ Preterm Deliveries: _____Miscarriages:_____

Do you consider this pregnancy to be high risk? YES NO
If yes, why? _____
Have you had any problems during this pregnancy? YES NO
If yes, what? _____
Have you had chicken pox or the vaccination? YES NO
Have you had a flu shot this year? YES NO

Previous pregnancy history: (If twins, please label)

Baby #1
Date of delivery: _____ Gender: _____ Name of baby: _____
Birth Weight: _____ Completed weeks of pregnancy: _____ Anesthesia: _____
Hospital, City, Delivering Physician: _____
Problems during delivery: _____
Vaginal, Cesarean, Vacuum, or Forceps: _____
Comments: _____

Baby #2
Date of delivery: _____ Gender: _____ Name of baby: _____
Birth Weight: _____ Completed weeks of pregnancy: _____ Anesthesia: _____
Hospital, City, Delivering Physician: _____
Problems during delivery: _____
Vaginal, Cesarean, Vacuum, or Forceps: _____
Comments: _____

Baby #3
Date of delivery: _____ Gender: _____ Name of baby: _____
Birth Weight: _____ Completed weeks of pregnancy: _____ Anesthesia: _____
Hospital, City, Delivering Physician: _____
Problems during delivery: _____
Vaginal, Cesarean, Vacuum, or Forceps: _____
Comments: _____
For MA: Height: _____ Wt: _____ BP: _____

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Genetic Screening (includes patient, baby's Father, or anyone in either family with):

YES NO Thalessemia
YES NO Neural Tube Defect
YES NO Congenital Heart Defect
YES NO Down Syndrome
YES NO Tay-Sachs
YES NO Canavan Disease
YES NO Familial Dysautonomia
YES NO Sickle Cell Disease/Trait
YES NO Hemophilia or other Blood Disorder
YES NO Muscular Dystrophy
YES NO Cystic Fibrosis
YES NO Huntington's Chorea
YES NO Mental Retardation/Autism
YES NO Fragile X
YES NO Other inherited or genetic chromosomal disorder
YES NO Other child(ren) with birth defects
YES NO Other: _____

Infection History

YES NO Live with someone with TB or exposed to TB
YES NO History of STD: Gonorrhea, Chlamydia, HPV, HIV, Syphilis, Trichomonas (CIRCLE IF "YES")
YES NO HIV
YES NO Personal history of genital herpes
YES NO Partner with history of genital herpes
YES NO Rash or Viral Illness since last menstrual period
YES NO Hepatitis B, Hepatitis C

Additional Comments: _____

Additional Information Pertinent To This Pregnancy

YES NO Will you be 35 years or older at due date?
YES NO Did you conceive by IVF?
YES NO Do you have an abnormality of your uterus?
YES NO Have you had a second or third trimester loss, incompetent cervix or preterm delivery?
YES NO Do you have diabetes or a history of gestational diabetes?
YES NO Do you have high blood pressure or a history of high blood pressure in pregnancy or pre-eclampsia?
YES NO Do you own a cat? Who changes litter box? _____
YES NO I am aware of the risks to myself and my baby of using alcohol, illicit or recreational drugs, and smoking during pregnancy
YES NO In the past year, have you been threatened, hit, slapped, or kicked by anyone you know?
YES NO Have you used any hot tubs, saunas, or steam baths during this pregnancy

Additional Comments: _____
_____