

Patient Label

Prenatal Genetic Screening Questionnaire

Patient name: _____ Partner's name (optional): _____
 Pronouns: She/her He/him They/them Other
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 Date of birth: _____ Occupation: _____ Date of birth: _____ Occupation: _____

Family and Patient Histories

1. Are the biological parents of the pregnancy:
 - a. Southeast Asian, Taiwanese, Chinese, or Filipino? No Yes
 - b. Italian, Greek, Middle Eastern, or Indian Subcontinent? No Yes
 - c. African or African-American (Black)? No Yes
 - d. Jewish? No Yes
 - e. Cajun or French Canadian? No Yes
 - f. Caucasian? If yes, what country? _____ No Yes
 - g. Hispanic? If yes, what country? _____ No Yes
2. Are the biological parents of the pregnancy related by blood (such as cousins)? No Yes
3. Has either biological parent, or anyone in their families, ever had any of the following?
 - a. Chromosomal abnormalities (such as Down syndrome) No Yes
 - b. Neural tube defect (spina bifida, anencephaly) No Yes
 - c. Blood disorder (such as hemophilia, sickle cell, thalassemia, clotting disorder) No Yes
 - d. Nerve or muscle disorder (such as neurofibromatosis, muscular dystrophy) No Yes
 - e. Bone or skeletal disorder (such as dwarfism) No Yes
 - f. Cystic fibrosis (a lung disease) No Yes
 - g. Kidney abnormalities No Yes
 - h. Heart defect (at birth) No Yes
 - i. Cleft lip/palate No Yes
 - j. Intellectual disability/Autism/Developmental delay No Yes
 - k. A baby who died shortly after birth or in childhood? No Yes
 - l. A stillbirth or two or more miscarriages? No Yes
 - m. Needed surgery before one year of age? No Yes
 - n. Cancer in childhood or young adulthood? No Yes
 - o. Blindness or deafness not related to age? No Yes
 - p. Any genetic condition not listed above: _____ No Yes
 - q. Any birth defect not listed above: _____ No Yes
 - r. A medical problem that you are concerned about? _____ No Yes
4. Has either biological parent had any genetic tests (such as cystic fibrosis, Tay-Sachs, Canavan or sickle cell screening)? If yes, please specify: _____ No Yes

Current pregnancy history (if applicable)

5. Was this pregnancy started through in-vitro fertilization (IVF) or other reproductive technology? No Yes
 If yes, please specify: sperm donor egg donor (donor age) _____ ICSI Other: _____
6. Have you used medications (excluding vitamins), tobacco, alcohol or recreational drugs? No Yes
7. Do you have diabetes (gestational, type 1 or type2)? No Yes
8. Have you had the California Prenatal Screening Program blood test? If yes, when? _____ No Yes
9. Have you had cell-free DNA screening (NIPT, NIPS)? If yes, when? _____ No Yes
10. If yes to any question above, explain: _____

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|-------------|-----------------------------|
| Date: _____ | Genetic Counselor Signature |
| Time: _____ | Print Name: |

