## PRENATAL SCREENING QUESTIONNAIRE

1. Will you be under the age of 17 when you deliver? ……………………….. Y N

2. Will you be 35 or older when you deliver? ………………………………….. Y N

3. Have you had a previous baby with a GBS (Group B Streptococcus/Group B Strep) infection? ……………………………………………………………..………….. Y N

4. Have you ever had a partner with Herpes? ………………………………….. Y N

5. Since your last menstrual period have you had any of the following symptoms:

    a. Rash or Viral Illness...................…………………………… Y N
    b. Abdominal Pain……………………………..………… Y N
    c. Blood in Stool or Urine……………………………………. Y N

6. Please describe any uterine abnormalities from your medical history below:

______________________________________________________________

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______________________________________________________________

7. Rarely, blood loss at the time of delivery can be excessive. Do you have any objections to receiving blood products should the need arise?……………………….……….. Y N

8. A blood test can be performed to determine the presence of the HIV antibody. This test shows if you have antibodies to the virus that cause AIDS. A positive test result means that you have been exposed to the virus and that you are infected. It does not mean that you have AIDS or that you will necessarily become sick with AIDS in the future. A negative test result means that you are probably not infected with the virus. However, it does take time for the body to produce HIV antibodies. Taking the HIV test is voluntary.

    Do you object to an HIV antibody test being drawn?………………………….. Y N

9. Have you had a prior singleton preterm birth between 20 weeks and 36 weeks and 5 days of pregnancy?…………………………………………………….……………….. Y N

10. In the last 6 months, have you or your partner traveled to Florida, Texas, or out of the country in this pregnancy? ………………………………………………….……………….. Y N
    a. If yes: Self Partner

11. Have you, your partner, or a close relative in either family had the following:

a. Thalassemia (Italian, Greek, Mediterranean, or Asian Background) Y N
   i. If yes: Self Partner
b. A-Thalassemia (Phillipine or Southeast Asian Background)……… Y N
   i. If yes: Self Partner
c. Spina Bifida, Anecephaly or Meningomyelocele (open spine) Y N
   i. If yes: Self Partner
d. Congenital Heart Disease ……………………………………….. Y N
   i. If yes: Self Partner
e. Down's Syndrome ......................…………………………… Y N
   i. If yes: Self Partner
f. Tay-Sachs Disease (Jewish, Cajun, French-Canadian Background) Y N
   i. If yes: Self Partner
g. Sickle Disease/Trait (African, African-American Background)……. Y N
   i. If yes: Self Partner
h. Hemophilia or other inherited blood coagulation problem …. Y N
   i. If yes: Self Partner
i. Cystic Fibrosis…………………………………………………... Y N
   i. If yes: Self Partner
j. Huntington's Chorea…………………………………………… Y N
   i. If yes: Self Partner
k. Cleft lip or palate………………………………………………… Y N
   i. If yes: Self Partner
l. Toxic environment or occupational exposure……………….. Y N
   i. If yes: Self Partner
m. Mental retardation or autism…………………………………... Y N
   i. If yes: Self Partner
n. Recurrent pregnancy loss or stillbirth………………………… Y N
   i. If yes, how many: ________________________
o. Other inherited, genetic, chromosome disorder……………. Y N
   i. If yes: Self Partner

Please describe:___________________________________________

_________________________________________________________

p. A child born dead or alive with a birth defect or mental retardation not listed above……………………………………………………. Y N
   i. If yes: Self Partner

Please describe:___________________________________________

_________________________________________________________

q. Muscular Dystrophy……………………………………......... Y N
   i. If yes: Self Partner

12. If you answered YES to any of the above questions (11a-q), do you wish to speak to a genetic counselor?............................................ Y N

13. Are you or your partner current smokers……………………………….. Y N
    a. If yes: Self Partner
        i. Type: □ Cigarettes □ Pipe □ Cigars
        ii. Frequency____________________

14. Do you drink alcoholic beverages during pregnancy?......................... Y N
    a. If yes, please describe how often and the quantity:
        i. _____ Glasses of Wine (5 oz) per □ day □ week
        ii. _____ Cans of Beer (12 oz) per □ day □ week
        iii. _____ Mixed Drinks per □ day □ week
        iv. _____ Martini/Manhattan per □ day □ week
        v. _____Shots of liquor per □ day □ week

15. Do you or your partner use recreational drugs?................................. Y N
    a. If yes: Self Partner
        i. Type: □ IV □ Marijuana □ Cocaine □ Amphetamines □ Narcotics
           □ Heroin □ Ecstasy □ Crystal Meth □ Barbiturates
           □ Benzodiazepines □ Opiates □ PCP (Phencyclidine)
           □ LSD
        ii. Frequency______________________

16. Do you take any prescriptions or over-the-counter medications?............... Y N

    If YES, please list the medication(s) and describe how often and the quantity:

    ________________________________________________________________

    ________________________________________________________________

17. Do you have a cat living in your household?.............................................. Y N

18. Testing is available to estimate the chance that your baby may be affected by chromosomal disorders such as Down Syndrome and uncommon conditions known as Trisomy 13 and Trisomy 18. This test, will also identify the sex of the baby (if requested).
    Genetic screening is a non-invasive test. An ultrasound and a blood test are done at approximately the 12th week of your pregnancy. The baby's father can provide a cheek swab which may be needed to evaluate for these genetic disorders but it is not mandatory. A second blood test, Alpha-Fetoprotein Screening (AFP), is then taken at approximately the 16th week of your pregnancy. The AFP test is measuring high and low levels of alpha-fetoprotein. The results are combined with the mother's age and ethnicity in order to assess probabilities of potential neural tube defects.

    Are you interested in considering this test?........................................... Y N

19. It is recommended that all women who will be pregnant during the influenza (flu) season be vaccinated.

    Are you interested in considering the Influenza Vaccine?......................... Y N

______________________________________ ____________________
(Signature) (Date)