PRENATAL SCREENING QUESTIONNAIRE

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

2. Have you, your partner, or a close relative in either family had the following:
   a. Down’s Syndrome ................................................................. Y  N
   b. Spina Bifida or Meningomyelocele (open spine) ............... Y  N
   c. Hemophilia ........................................................................ Y  N
   d. Muscular Dystrophy .............................................................. Y  N
   e. Cystic Fibrosis ..................................................................... Y  N

3. Have you, your partner, or a close relative had a child born dead or alive with a birth defect or mental retardation not listed in Question #2 above?... Y  N

4. Do you, your partner, or a close relative in either family have any inherited genetic or chromosomal disease or disorder not listed above?..................... Y  N

5. Have you or your partner had 3 or more spontaneous pregnancy losses (miscarriages, stillbirths, etc.)?................................................................. Y  N

6. Do you or your partner have any close relatives who have descended from Eastern European Jews (Ashkenazi Jews)?............................................... Y  N

   If YES, have either you or your partner been screened for Tay-Sachs disease.................................................................................................................. Y  N

   If YES, who was screened and please indicate the results of the screening:

   _______________________________________________________________________________________

7. Are you or your partner African American?................................. Y  N

   If YES, have you, your partner, or any close relative in either family been screened for the Sickle Cell trait?................................................................. Y  N

   If YES, who was screened and please indicate the results:

   _______________________________________________________________________________________

   _______________________________________________________________________________________
8. Do you or your partner have any close relatives from Mediterranean countries? .......................................................... Y  N

If YES, have you or your partner been screened for Thalassemia (Cooley’s anemia)? .......................................................... Y  N

If YES, who was screened and please indicate the results:

__________________________________________________________________

9. 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

10. Do you drink alcoholic beverages during pregnancy? .......................... Y  N

If YES, please describe how often and the quantity:

__________________________________________________________________

__________________________________________________________________

11. 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:

__________________________________________________________________

__________________________________________________________________

12. If you answered YES to any of the above questions (1-11), do you wish to speak to a genetic counselor? .......................................................... Y  N

13. Do you have a cat living in your household? ........................................ Y  N
14. Testing is available to estimate the chance that your baby may be affected by Down’s Syndrome, open neural tube defects (such as Spina Bifida), and an uncommon condition known as Trisomy 18. This is called Sequential Screening. Sequential Screening is a two-step process. First, an ultrasound and a blood test are done between the 11th and 13th week of your pregnancy. A second blood test is then taken between the 15th and 18th week of your pregnancy. For almost all women who have this screening, results will be available after the second blood test. A few women will have a positive result after the first blood test, and will not need to have the second blood draw.

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

15. 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

16. 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)