

Center for Prenatal Diagnosis

Name: _____ Birth date: _____

Your appointment date: _____ Reason for Appointment: _____

Family and Pre-Pregnancy History Form

Approximately 3-5% of all babies are born with some type of birth defect. This is the normal background rate at which things can go wrong during a baby's development. These questions will help us learn about your family history, and will help determine whether your chance of having a baby with a birth defect is higher than this population risk. A genetic counselor, nurse or physician will discuss your answers with you and will discuss any additional questions you may have. All information on this form will be kept confidential. Please circle your answers or fill in the blanks.

- 1) Will you be 35 or older when delivering a pregnancy? Yes No
- 2) What is the name of your partner? _____
- 3) Is the potential baby's father 55 or older? Yes No
- 4) Are you and the potential baby's father blood relatives? Yes No
- 5) Which ethnicity do you consider yourself and the potential baby's father to be?

<u>You:</u>	White or Caucasian	<u>The potential</u>	White or Caucasian
	Black or African American	<u>baby's father:</u>	Black or African American
	Hispanic		Hispanic
	Asian or Pacific Islander		Asian or Pacific Islander
	Mediterranean		Mediterranean
	Jewish		Jewish
	Other: _____		Other: _____

- 6) About how many cigarettes do you smoke **per day** on average? _____ pack(s)
- 7) About how many alcoholic beverages do you consume **per day** on average? _____
- 8) Do you currently use any street drugs? Yes No
- If so, please list which substances. _____
- 9) Are you currently taking folic acid, a multivitamin or prenatal vitamins? Yes No
- 10) Do you take any medications or over the counter drugs on a regular basis? Yes No
- Please list all substances taken, the doses consumed, and the reason for taking each substance.
- _____
- 11) Do you have a seizure disorder? Yes No
- 10) Do you have insulin-dependent diabetes? Yes No
- 11) How many children have you given birth to? _____
- 12) Please list your children's names and ages. _____
- _____

13) How many miscarriages have you had? _____ How many stillbirths have you had? _____

If you had one or more miscarriages or a stillbirth, how far along were you when you lost the pregnancy and was there any evaluation(s) performed to identify the cause?

14) How many elective abortions have you had? _____

15) Please indicate if anyone in your family, or the potential father of the baby's family, has any of the following conditions. **You and your partner's family members are considered to be: your children, brothers, sisters, nieces, nephews, parents, aunts, uncles, first cousins, half-siblings and their children, and your grandparents.**

Cystic fibrosis	Yes	No	Spina bifida (open spine)/Anencephaly	Yes	No
Cleft lip or palate	Yes	No	Hydrocephalus (water on the brain)	Yes	No
Down syndrome	Yes	No	Childhood loss of hearing or eyesight	Yes	No
Autism	Yes	No	Learning problems/mental retardation	Yes	No
Skeletal abnormality	Yes	No	Bleeding/clotting problem	Yes	No
Sickle cell disease/trait	Yes	No	Muscular dystrophy/muscular weakness	Yes	No
Heart defect at birth	Yes	No	Thalassemia (a hereditary anemia)	Yes	No
Stillbirth or infant death	Yes	No	More than 3 miscarriages	Yes	No
Birth defects	Yes	No	Other: _____		

If you answered yes to any of the conditions above, please tell us who had the condition, how they are related to you or the potential baby's father, and any other information you know.

Please list any specific questions you would like addressed during your counseling session.

If you have any other health or family history concerns not listed above in addition to the reason for your appointment, please consult with your physician about a separate referral or appointment to address your specific needs.