Genetic Screening Questionnaire

Patient Name: _____ Date of Birth: _____

Doctor/Clinic: _____ Today's Date: _____

The following questionnaire will help identify genetic risk factors that may affect you or your children. Your answers may indicate that certain tests would be appropriate. Please answer all questions as completely as possible. All information will be kept confidential.

1. If you are pregnant, will you be 35 or older at your due date?
   ☐ Yes ☐ No Your due date is: _____

2. Are you, the father of the pregnancy, or your ancestors from any of these ethnic backgrounds: Asian (except Japanese or Korean), Southeast Asian, Pacific Islander, Mediterranean, Southern European, Central American, South American, Caribbean, Middle Eastern, or African American or Black?
   ☐ Yes ☐ No ☐ Don't know

3. Have you or the father of the pregnancy been tested to see if you are a carrier of thalassemia, sickle cell anemia, or another hemoglobin abnormality?
   ☐ Yes ☐ No ☐ Don't know
   If yes, who was tested or what were the results? _____

4. Are you or the father of the pregnancy of Jewish, French Canadian, or Cajun background?
   ☐ Yes ☐ No ☐ Don't know

5. Have you or the father of the pregnancy had carrier testing for any other genetic diseases?
   ☐ Yes ☐ No ☐ Don't know
   If yes, who was tested or what were the results? _____

6. Were you, the father of the pregnancy, or anyone in your families born with an opening In the spine or head (such as a neural tube defect, spina bifida, or anencephaly)?
   ☐ Yes ☐ No ☐ Don't know
   If yes, please write the diagnosis or describe the defect _____
   How is the person related to you or the father of the pregnancy? _____

7. Were you, the father of the pregnancy, or anyone in your families born with a heart defect, cleft lip, or cleft palate?
   ☐ Yes ☐ No ☐ Don't know
   If yes, please write the diagnosis or describe the defect. _____
   How is the person related to you or the father of the pregnancy? _____

8. Have you, the father of the pregnancy, or anyone in your families had a pregnancy or a child diagnosed with Down syndrome or any other chromosome abnormality?
   ☐ Yes ☐ No ☐ Don't know
   If yes, how is this person related to you or the father of the pregnancy? _____

9. Do you, the father of the pregnancy, or anyone in your families have hemophilia or another bleeding disorder?
   ☐ Yes ☐ No ☐ Don't know
   If yes, please write the diagnosis or describe the disorder._____
   How is the person related to you or the father of the pregnancy? _____

10. Have you, the father of the pregnancy, or anyone in your families been diagnosed with spinal muscular atrophy, muscular dystrophy, or another neuromuscular disease?
    ☐ Yes ☐ No ☐ Don't know
    If yes, please write the diagnosis or describe the disease. _____
    How is the person related to you or the father of the pregnancy? _____

11. Do you, the father of the pregnancy, or anyone in your families have cystic fibrosis?
☐ Yes ☐ No ☐ Don't know
If yes, how is this person related to you or the father of the pregnancy? _____

12. Do you, the father of the pregnancy, or anyone in your families have autism, mental retardation, or fragile X syndrome?
☐ Yes ☐ No ☐ Don't know
If yes, please write the diagnosis or describe the disorder. _____
How is this person related to you or the father of the pregnancy? _____

13. Did you, the father of the pregnancy, or anyone in your families have any other birth defect or serious medical condition in infancy or childhood?
☐ Yes ☐ No ☐ Don't know
If yes, please describe. _____
How is the person related to you or the father of the pregnancy? _____

14. Do you have diabetes, a seizure disorder (epilepsy), lupus PKU (phenylketonuria), or another chronic medical condition?
☐ Yes ☐ No
If yes, please write the diagnosis. _____

15. Do you, the father of the pregnancy, or anyone in your families have an inherited disorder or birth defect not previously mentioned in this questionnaire?
☐ Yes ☐ No ☐ Don't know
If yes, please write the diagnosis or describe the defect. _____
How is the person related to you or the father of the pregnancy? _____

16. Are you related to the father of the pregnancy (other than by marriage)?
☐ Yes ☐ No
If yes, how? _____

17. Do you have a history of premature ovarian insufficiency (or loss of normal ovarian function prior to age 40)?
☐ Yes ☐ No

18. Have you or the father of the pregnancy had a stillborn child or two or more pregnancy losses in this or any other relationship?
☐ Yes ☐ No ☐ Don't know
If yes, please describe. _____

19. Was this pregnancy conceived through IVF?
☐ Yes ☐ No

If yes, was ICSI or PGD (preimplantation genetic diagnosis) used?
☐ Yes ☐ No

20. Have you taken any recreational drugs, had any alcoholic drinks, or taken any medications (other than prenatal vitamins) since your last menstrual period?
☐ Yes ☐ No ☐ Don't know
If yes, please describe. _____

☐ I have answered these questions to the best of my knowledge.

Patient Signature: _____ Date: _____

Source: Integrated Genetics LabCorp Specialty Testing Group – Genetic Screening Questionnaire. 2012 - Laboratory Corporation of America Holdings.