Stanford Children's Health | Lucile Packard Children's Hospital Stanford

Lucile Salter Packard Children's Hospital
STANFORD UNIVERSITY MEDICAL CENTER ● 725 Welch Road, Palo Alto, CA 94304

CLINIC VISIT • OB GENETICS CLINIC• PRENATAL GENETIC SCREENING QUESTIONNAIRE

Medical Record Number

Patient Date of Birth:

Patient Label

Patient name: ______________________ Partner's name: ______________________
Date of birth: __________ Occupation: ______________ Date of birth: __________ Occupation: ______________

Family and Patient Histories

1. Is your family or the father of the pregnancy's family:
   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? .... No Yes
   g. Hispanic? If yes, what country?______________ .... No Yes
2. Are you and the father of the pregnancy related by blood (such as cousins)? .... No Yes
3. Have you, the father of the pregnancy, or anyone in either of your 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. Have you or the father of the pregnancy had any genetic tests (such as cystic fibrosis, Tay-Sachs, Canavan or sickle cell screening)? No Yes
   If yes, please specify: ______________________

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? ______________
9. Have you had cell-free DNA screening (NIPT, NIPS)? If yes, when? ______________ No Yes
10. If yes to any question above, explain:______________________ No Yes

______________________ ______________
SIGNATURE (Patient, Parent, or Properly designated representative) Date

DATE: TIME:	Genetic counselor signature
	PRINT name: