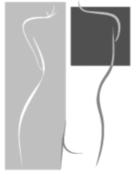

PRECONCEPTION/GENETIC QUESTIONNAIRE

Name:___________________________ **Date:** _________
Partner's Name: ___________________________________

Height ___________ **Weight** ___________ **BMI** ____________ **BP** __________________

Please circle Y or N

Y N Have you ever been pregnant before?
If yes: Total number of pregnancies ________ Number of living children ________________
Were there any complications with these pregnancies: ____
Y N Will you be 35 or older when this child is born?

Please indicate if you, your partner/husband, or anyone in your family has had the following:

a. 2 or more miscarriages	Y	N	b. A child with a birth defect	Y	N
c. A chromosomal abnormality	Y	N	d. Down's syndrome	Y	N
e. Muscular dystrophy	Y	N	f. Hemophilia/Bleeding disorders	Y	N
g. Cystic fibrosis	Y	N	h. Neural tube defects/spina bifida	Y	N
i. Mental retardation					

Do you or your partner have any of the following medical conditions:

a. Diabetes	Y	N	b. PKU	Y	N
c. Lupus	Y	N	d. Thyroid disease	Y	N
e. Deep venous thrombosis	Y	N	f. Depression	Y	N

Y N Are you or your partner of Ashkenazi Jewish descent?
Y N If yes, have you been tested for Tay Sachs disease or Canavan's disease?
Y N Are you or your partner of African American or of African descent?
Y N If yes, have you been tested for Sickle Cell disease?
Y N Are you or your partner of Southeast Asian or Phillipine descent?
Y N If yes, have you been tested for Thalassemia?
Y N Are you or your partner of Greek or Italian descent?
Y N If yes have you been tested for thalassemia?
Y N Do you currently take any prescription or non-prescription medications?
If yes, please list ____
Y N Are you currently taking a prenatal vitamin?
Y N Do you or you partner smoke?
Y N Do you drink alcohol?
Y N Do you use any recreational drugs?
Y N Are you exposed to any chemical agents in the workplace or at home?
Y N Are your immunizations up to date, including Rubella, Hepatits B, and tetanus?
Y N Did your mother receive DES when pregnant with you?
Y N Do you own cats?
Y N Do you eat rare or raw meat?
Y N Have you had the chicken pox or have you received the vaccination for chicken pox?
Y N Do you or your partner have a history of genital herpes, either type 1 or 2?
Y N Are you an athlete (i.e. run marathons, run >5 miles/day, exercise >2 hours/day) ?
What is your occupation? ____

Do you or your partner have any other family history of concern to you (please list below)?
____

Recommendations/Plan

□ Prenatal Vitamin	□ Day 3 labs	□ Other blood work
□ Dietary counseling	□ Semen Analysis	□ Other ____
□ Exercise counseling	□ Ultrasound	____