MID SOUTH MATERNAL FETAL MEDICINE, P.C.

GENETIC COUSELING INFORMATION SHEET

Please complete the following information on you, your family and the father of the baby and his family. Try to answer all questions completely and accurately. If you need more room you may write on the back of the page.

PATIENT INFORMATION:

Your Name: ____________________ **Birth Date:** ____________

Your Address: ________________________________

Race: ________ **Religion:** ________ **Occupation:** ____________

Marital Status: ☐ **Single** ☐ **In a relationship** ☐ **Married** ☐ **Divorced** ☐ **Separated**

REFERRING PHYSICIAN:

Physician's name: ________________ **Phone number:** ____________

Physician's address: ________________________________

PREGNANCY HISTORY:

Have you had any complications with your current pregnancy: ☐ **Yes** ☐ **No**

What complications have you had? ________________________________

____

Have you had any miscarriages or pregnancy losses? ☐ **Yes** ☐ **No**

When were your miscarriages and how far along was the pregnancy in each case?

____

____

____

____

Do you know if the current pregnancy has been screened for genetic conditions, such as Down Syndrome or recessive conditions? ☐ **Yes** ☐ **No**

When the results of the chromosome studies are given, do you want to know the sex of the baby?

☐ **Yes** ☐ **No**

INFORMATION ABOUT YOUR FAMILY:

Please list ALL of your children in order of birth.

Child's Name	Child's Age	Sex/Gender	Health Concerns?	Child or Stepchild?

Is your mother living? ☐ **Yes** ☐ **No** **What is her age now/age at death? __________**

How many brothers and sisters does/did your mother have: **Brothers _____** **Sisters _____**

Is your father living? ☐ **Yes** ☐ **No** **What is his age now/age at death? __________**

How many brothers and sisters does/did your father have: **Brothers _____** **Sisters _____**

Please list all of your siblings/brothers/sisters and tell us if each has the same mother and/or father as you:

Sibling's Name	Sibling's Age	Sex/ Gender	Health Concerns?	Same Mom AND Dad	Same Mother only	Same Father only
EXAMPLE: Henry	25	Male	Kidney disease		X	

INFORMATION ABOUT THE FATHER OF THE BABY (for the current pregnancy)

Last Name: ________________________________ First Name: ____________________________________
Age: _____ Religion: ________________ Race: __________ Occupation: _________________
Cell Phone: _____________________________________

Is his mother living: ☐ Yes ☐ No What is her current age/age at death? _____________
How many brothers and sisters does/did she have? Brothers _____ Sisters _____

Is his father living: ☐ Yes ☐ No What is his current age/age at death? _____________
How many brothers and sisters does/did he have? Brothers _____ Sisters _____

Please list all the Father of the Baby's siblings and tell us if each has the same mother and/or father as him:

Sibling's Name	Sibling's Age	Sex/ Gender	Health Concerns?	Same Mom AND Dad	Same Mother only	Same Father only
EXAMPLE: Henry	25	Male	Kidney disease	X		

MATERNAL PRENATAL SCREEN:

	Yes	No
Down Syndrome?	Yes ☐	No ☐
Other Chromosomal abnormality?	Yes ☐	No ☐
Neural Tube Defect (spina bifida, meningomyelocele, open spine, anencephaly)?	Yes	No
Hemophilia	Yes	No
Muscular Dystrophy	Yes	No
Cystic Fibrosis	Yes	No

Will you be 35 years old or older when the baby is due? ☐ Yes ☐ No

Have you, the Father of the Baby or anyone in either of your families ever had any of the following?

☐ ☐
☐ ☐
☐ ☐
☐ ☐

If Yes to any of the above, please indicate the relationship of the affected person to you or the Father of the Baby.

Do you or the baby's father have a birth defect? ☐ Yes ☐ No

If yes, indicate the type of defect and who is affected:

In any previous marriages/relationships, have you or the baby's father had a child with a birth defect not listed in the question above? If yes, what is the defect and who had it?

Do you or the baby's father have any close relatives with intellectual disability? ☐ Yes ☐ No

If yes, indicate the relationship of the affected person to you or to the baby's father. Indicate the cause if known.

Do you, the baby's father or any close relatives in either of your families have a birth defect, familial disorder or chromosomal abnormality not listed above? ☐ Yes ☐ No

If yes, indicate the condition and the relationship of the affected person to you or to the baby's father

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In any previous marriage/relationship, have you or the baby's father had a stillborn child or 3 or more pregnancy losses before 14 weeks gestation? ☐ Yes ☐ No

Have you or the baby's father been screened for Tay-Sachs disease, sickle cell trait, a-thalassemia, or b-thalassemia? ☐ Yes ☐ No

If yes, indicate who was tested and what the results were:

Excluding vitamins, have you taken any medications or recreational drugs since being pregnant or since your last menstrual period? (Include both prescription and non-prescription drugs) ☐ Yes ☐ No

If yes, what medication did you take and when in the pregnancy did you take it?