GENETIC COUNSELING 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, write on back of page.

Patient Information

Last Name	First Name	MI	Maiden Name
Race	Religion	Birth Date	Occupation
Home Address			
City		State	Zip
Marital Status: ❑ Single	❑ Married	❑ Divorced	❑ Separated

Patient Current Medical History

When was your last menstrual period? _____

What is your due date: _____

Have you had an ultrasound during this pregnancy? ❑ Yes ❑ No

Have you had a fever during this pregnancy? ❑ Yes ❑ No

Have you had diabetes prior to or during this pregnancy? ❑ Yes ❑ No

Have you consumed any alcohol during this pregnancy? ❑ Yes ❑ No

Do you smoke? ❑ Yes ❑ No

If yes, how many per day? _____

Have you taken any medications during this pregnancy? ❑ Yes ❑ No

If yes, please list: _____

Have you had any complications with this pregnancy? ❑ Yes ❑ No

If yes, please explain: _____

Have you had any miscarriages? ❑ Yes ❑ No

If yes, please list dates: _____

When the results of the chromosome studies are given, do you want to know the sex of the fetus? ❑ Yes ❑ No

Referring Physician Information

Physician's Full Name _____ Phone Number _____

Address: _____

City _____ State _____ Zip Code _____

PATIENT FAMILY HISTORY

Please list all of your children in order of birth; indicate if child or stepchild.

FULL NAME	AGE	STATE OF HEALTH	CHILD/STEPCHILD

Is your mother living? ❑ Yes ❑ No What is her current age/was her age at death?_____

How many brothers/sisters did your mother have? Brothers _____ Sisters _____

Is your father living? ❑ Yes ❑ No What is his current age/was his age at death?_____

How many brothers/sisters did your father have? Brothers _____ Sisters _____

Please list all of your siblings in order of birth; indicate if brother, sister, half-brother or half-sister.

FULL NAME	AGE	STATE OF HEALTH	BROTHER/SISTER HALF-BROTHER/HALF-SISTER

INFORMATION ABOUT THE FATHER OF THE BABY

Last Name _____ First Name _____

Age _____ Religion _____ Race _____ Occupation _____

Home Phone _____ Work Phone _____

Is his mother living? ❑ Yes ❑ No What is her current age/was her age at death?_____

How many brothers/sisters did his mother have? Brothers _____ Sisters _____

Is his father living? ❑ Yes ❑ No What is his current age/was his age at death?_____

How many brothers/sisters did his father have? Brothers _____ Sisters _____

Please list the father's siblings in order of birth; indicate if brother, sister, half-brother or half-sister.

FULL NAME	AGE	STATE OF HEALTH	BROTHER/SISTER HALF-BROTHER/HALF-SISTER

MATERNAL PRENATAL SCREEN

(THESE QUESTIONS TO BE ANSWERED BY PATIENT ONLY)

NAME _____ SOC. SEC.# _____ DATE _____

Will you be 35 years or older when the baby is due? ..... ❑ Yes ❑ No

Have you, the baby's father, or anyone in either of your families ever had any of the following disorders:

Down Syndrome (mongolism) ..... ❑ Yes ❑ No
Other chromosomal abnormality ..... ❑ Yes ❑ No
Neural tube defect, i.e. spina bifida (meningomyelocele or open spine), anecephaly ..... ❑ Yes ❑ No
Hemophilia ..... ❑ Yes ❑ No
Muscular Dystrophy ..... ❑ Yes ❑ No
Cystic Fibrosis ..... ❑ Yes ❑ No

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

_____

Do you or the baby's father have a birth defect? ..... ❑ Yes ❑ No
If yes, who has the defect and what is it? _____

In any previous marriages, have you or the baby's father had a child with a birth defect not listed in the question above? ..... ❑ Yes ❑ No
If yes, what is the defect and who had it? _____

Do you or the baby's father have any close relatives with mental retardation? ..... ❑ 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 a close relative in either of your families have a birth defect, familial disorder, or a chromosomal abnormality not listed above? ..... ❑ Yes ❑ No
If yes, indicate the condition and the relationship of the affected person to your or to the baby's father: _____

In any previous marriages, have you or the baby's father had a stillborn child or three or more first trimester pregnancy losses? ..... ❑ Yes ❑ No

If you or the baby's father are of Jewish ancestry, have either of you been screened for Tay-Sachs disease? ..... ❑ Yes ❑ No
If yes, indicate who and the results: _____

If you or the baby's father are African-American, have either of you been screened for sickle cell trait? ..... ❑ Yes ❑ No

If you or the baby's father are of Italian, Greek or Mediterranean background, have either of you been tested for *B*-thalassemia? ..... ❑ Yes ❑ No
If yes, indicate who and the results: _____

If you or the baby's father are of Philippine or Southeast Asian ancestry, have either of you been tested for *a*-thalassemia? ..... ❑ Yes ❑ No
If yes, indicate who and the results: _____

Excluding iron and vitamins, have you taken any medications or recreational drugs since being pregnant or since your last menstrual period? (include non-prescription drugs) ..... ❑ Yes ❑ No
If yes, give name of medication and time taken during pregnancy: _____