# HOUSTON PERINATAL ASSOCIATES

## GENETIC SCREENING FORM

**713-791-9700**

1. Patient's Name:

_______________________________________ ____________ ___________
Last First Maiden Date of Birth Blood Type

Father of the baby:______________________________ ____________
Last First Date of Birth

2. Your occupation:______________________________________________

Father's occupation:______________________________________________

3. Have you had any surgeries or chronic illnesses? Have you been on medication for extended periods? If so, please describe:_______________________________________
______________________________________________

4. List children, living or deceased (include those from previous marriages):

| Name | Age | Sex | General Health |
| --- | --- | --- | --- |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |

5. Have you had any miscarriages?____________________________________
______________________________________________

Have you had any stillborn infants? If so, please describe:_______________________
______________________________________________

6. Has there been any medication use in the current pregnancy (include prescription, over-the-counter, recreational drugs)? If so, give dates of use, amount, and name of drugs:_______
______________________________________________
______________________________________________

7. Has there been any tobacco use in the pregnancy?_______________________
How much alcohol has been used in the pregnancy?_______________________
Has there been any x-ray exposure in the pregnancy?_______________________

8. Have you had any spotting, bleeding, or any other complications?________________
______________________________________________
Have you had any illnesses, fever, or unusual rashes in the current pregnancy?__________
______________________________________________

9. Do you have any cats?____________________________________

10. Are you or the baby's father of:
Greek, Italian, or Asian ancestry?______________________________
Jewish ancestry?______________________________________
Black or East Indian ancestry?________________________________
French Canadian/Cajun ancestry?______________________________

11. Are you and the baby's father blood relatives?________________________________

12. Is there any history in your or the father's family of the following disorders? Include parents, brothers/sisters, nieces/nephews, aunts/uncles, grandparents, and first cousins. If so, mark the blank and list details at the bottom of this page:

_______Birth defects
_______Down syndrome (mongolism)
_______Mental retardation
_______Unexplained infant or childhood deaths
_______Spina bifida (open spine defect)
_______Hydrocephalus (water on the brain)
_______Hemophilia/bleeding disorders
_______Muscle disease (muscular dystrophy)
_______Multiple family members with the same trait or disease
_______Cystic fibrosis
_______Sickle cell disease/trait
_______Huntington's Chorea
_______Multiple miscarriages in relatives
_______Individuals much taller or shorter than the rest of the family
_______Individuals who look unusual or very different
_______Kidney disease
_______Blindness or deafness (congenital)
_______Cleft lip or cleft palate
_______Early onset heart disease (under 35 years)
_______Stillbirths in relatives
_______Early onset cancer (under 35 years)
_______Early onset emphysema (under 35 years)

Details of the above:________________________________________________________
____________________________________________________________________________
____________________________________________________________________________
____________________________________________________________________________
____________________________________________________________________________

13. Do you want to know the sex of the baby?__________________________________

14. Do you have any additional concerns not covered above?_______________________
____________________________________________________________________________
____________________________________________________________________________
____________________________________________________________________________
____________________________________________________________________________

Patient signature:____________________________________ Date:________________

Reviewer:___________________________________________________________