Rutland Women's Healthcare

A Department of Rutland Regional Medical Center

PRENATAL GENETIC SCREENING

Name: _____ DOB: _____ Today's date: _____

The answers to the following questions will help us give you better care. Please read them carefully as these questions pertain to you, your family, the father of your baby and his family. If you do not understand the questions, a nurse will help you complete your answer.

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1. Will you be age 35 or older when the baby is due? Yes___ No___

2. Have you, the baby's father or anyone else in either of your families ever had any of the following disorders?
   a. Down Syndrome ("mongolism") Yes___ No___
   b. Other Chromosomal abnormality Yes___ No___
   c. Neural tube defect, such as spina bifida (open spine), anencephaly Yes___ No___
   d. Hemophilia Yes___ No___
   e. Muscular Dystrophy Yes___ No___
   f. Cystic Fibrosis Yes___ No___

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

3. Do you or the baby's father have a birth defect? Yes___ No___
   If yes, who has the defect and what is it?
   _____

4. In any previous pregnancies, have you or the baby's father had a child born dead or alive with a birth defect not listed in question 2 above? Yes___ No___
   If yes, please describe the defect and who had it:
   _____

5. 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 and the cause if known:
   _____

6. Do you, the baby's father, or close relatives in either of your families have a birth defect, any familial or inherited disorder or a chromosomal abnormality not listed above? Yes___ No___
   If yes, indicate the condition and the relationship of the affected person to you or the baby's father:
   _____

7. In any previous pregnancies, have you or the baby's father had a stillborn child or two or more pregnancy losses? Yes___ No___
   If yes, please indicate if either of you had a chromosomal study and the results:
   _____

8. Are you or the baby's father of Jewish (Ashkenazi) or French Canadian ancestry? Yes___ No___
   If yes, have either of you been screened for Tay Sachs disease? Yes___ No___
   If yes, indicate who and the results:
   _____

9. Are you or the baby's father of African American ancestry? Yes___ No___
   If yes, have either of you been screened for sickle cell trait? Yes___ No___
   If yes, indicate who and the results:
   _____

10. Are you or the baby's father of Philippine or Southwest Asian ancestry? Yes___ No___
    If yes, have either of you been screened for alpha-thalassemia? Yes___ No___
    If yes, please indicate who and the results:
    _____

11. Are you or the baby's father of Italian, Greek or Mediterranean ancestry? Yes___ No___
    If yes, have either of you been screened for beta-thalassemia? Yes___ No___
    If yes, please indicate who and the results:
    _____

12. Excluding iron and vitamins, have you taken any medications, prescribed or over-the-counter, or any recreational drugs since your last menstrual period? Yes___ No___

13. If yes, list the name(s) of the medication(s) and when taken during pregnancy:
    _____
    _____

I certify that all medical information is complete and accurate.

Patient's Signature: _____ Date/Time: _____

Form completed and verified by nurse phone interview (nurse initials): _____