

Family and Pregnancy History

Name _____ Date _____

Please complete the following:

1. Has anyone in your family or your partner's family ever had:
 - a. Down's Syndrome yes no
 - b. Spinal Cord defects yes no
 - c. Hemophilia yes no
 - d. Muscular Dystrophy yes no
 - e. Heart defect (born with) yes no
 - f. Cystic Fibrosis yes no
 - g. Any other type of birth defect yes no

2. Will you be age 35, or older when the baby is born?
yes no

3. Do you have insulin dependent diabetes?
yes no

4. Have you had three or more miscarriages?
yes no

5. Have you during or immediately prior to this pregnancy:
 - a. taken any drugs or medications, including over the counter, prescription, illegal or herbal preparations?
yes no

6. Have you ever been tested to determine if you are immune to Rubella (German measles)? yes no

Certain Genetic Diseases are more common in certain ethnic groups.

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

8. If you or the baby's father are of Eastern European Jewish descent (Ashkenazi) have you been screened for Tay-Sach's yes no

9. If you or the baby's father are from Mediterranean or Southeast Asian countries have either of you been screened for Thalassemia?
yes no