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 defect ____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 the age of 35 or older when your 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 taken any drugs or medications (including over the counter, prescription, illegal or herbal preparations) during or immediately prior to this pregnancy? ____Yes ____No
6. Have you ever been tested to determine whether you are immune to Rubella (German measles)? ____Yes ____No

Certain Genetic Diseases are more common is 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 Eastern European Jewish descent (Ashkenazi), have either of you been screened for Tay-Sachs? ____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