Washington Women's Health Specialists
Part of Washington Township Medical Foundation

GENETIC HISTORY QUESTIONNAIRE

Please fill out this questionnaire. Your physician will discuss these answers with you during your visit.

Name:
Date:
Ethnicity:

* Are you or will you be 35 years or older at your estimated date of delivery? YES_____ NO_____
* Are you related to the father of the baby other than by marriage? If yes, specify your relationship below.

_____

Do you have a history of any of the following conditions in your family, or the family of the father of the baby? Please check yes or no. If you are unsure, please leave blank. If yes, please specify which family member.

CONDITION	YES	NO	PERSON IN THE FAMILY
Thalassemia			
Neutral tube defect (meningomyelocele, spina bifada, or anencephaly)			
Congenital heart defect			
Down syndrome			
Tay-Sachs			
Canavan disease			
Familial dysautonomia			
Sickle cell disease or trait			
Hemophilia or other blood disorders			
Muscular dystrophy			
Cystic fibrosis			
Huntington's chorea			
Developmental delay			
(if yes, was the person tested for Fragile X?)			
Autism			
Other inherited genetic or chromosomal disorder			
Maternal metabolic disorder (e.g., Type 1 diabetes, PKU)			
Recurrent pregnancy loss, or a stillbirth			

Any other birth defects not listed here? _____

Have you used any medications (incl. supplements, vitamins, herbs, over-the-counter medications) or illicit/recreational drugs/alcohol since your last menstrual period? If yes, please specify.