

Patient Name: _____ Date Of Birth: _____

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Why is the doctor referring you to Genetics? _____

Are you/your partner currently pregnant? Yes No
(If you are not currently pregnant, skip to next page)

How many TOTAL times have you been pregnant? 0 1 2 3 4 5 6 _____

How many live born children? _____ How many miscarriages? _____

How many abortions? _____ How many stillbirths? _____

Was this a planned pregnancy? Yes No Is it twins or triplets? Yes No

Was this a natural conception? Yes No

If No

Reason for Infertility: _____

Infertility treatment used: _____

Egg source: Mother Donor Sperm source: Father Donor

What was your Last Menstrual Period date? ____/____/____

What is the baby's due date? ____/____/____

How early did you know you were pregnant? _____ weeks

When did you start to see a doctor? _____ weeks

When did you start taking prenatal vitamins? Before conception or _____ weeks

What other medicines or herbal supplements are you taking?

Medication Name	Reason for Medicine	Started When?	Stopped When?

Which of these have you had:

____ 1st trimester screen (Nuchal thickness test) ____ Chorionic Villus Sampling

____ Maternal serum screen ("Triple test") ____ Amniocentesis

____ Routine ultrasound at your doctor ____ PUBS

____ Special ultrasound at a perinatologist ____ Fetal MRI

____ 3D ultrasound ____ Fetal echocardiogram

Do you have gestational diabetes? Yes No

What other illness are you having during your pregnancy?

Illness	Started When?	Were you hospitalized?

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What long term health problems do you have? _____

How old were you when the problems started? _____

What problems did you see first? _____

Over time, have the problems been: BETTER WORSE THE SAME

For women: How old were you when your period started? _____

The next questions are about your social habits, lifestyle and exposures:

Do you smoke tobacco? Yes No Do you chew tobacco? Yes No

How many per day? _____ A can lasts how long? _____

Do you smoke marijuana? Yes No

How often? _____

Do you drink alcohol? Yes No

How often? _____ How much at one time? _____

Do you use illicit drugs? Yes No

Which drug(s)? Cocaine/Crack Heroin Meth Ecstasy Other

How often? _____

Are you sexually active? Yes No

What is your sexual orientation? Heterosexual Homosexual Bisexual

Who lives with you? Live Alone Spouse/Partner Children Other

What do you do for a living? _____

What does your Spouse/Partner do? _____

Are you exposed to anything at work that concerns you? Yes No

If Yes, what is it? _____

The next questions are about your educational history.

How far did you get in school?

Less than high school High school graduate Some college
2-year College Degree 4 year College degree Graduate School

Were you ever in Special Education or Resource classes? Yes No

Circle any of the therapies that you ever received:

Physical Therapy Occupational Therapy Speech Therapy None

The next questions are about your health.

What medications do you take? _____

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Have you ever had any surgeries? Yes No
If Yes, please fill in the table

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Surgery done	Reason for surgery	What age

Do you have any piercings? Yes No Tatoos? Yes No
For men: Are you circumcised? Yes No

Have you ever been hospitalized for any other reason besides surgery? Yes No
If Yes, please fill in the table

Reason for hospitalization	What age

That ends the entry questions. Please gather any other information you think may be important.

You will be asked detailed questions about the family. Filling out this form ahead of time gives you a chance to gather important information and will save time during the clinic visit.

It is also helpful to see pictures of the patient at younger ages and of other family members. It is especially good to bring pictures of anyone who you think looks like the patient.