

Association in Women's Care Genetics Questionnaire

Name: _____ Spouse's Name: _____

Please answer "yes" or "no", as appropriate, and bring this sheet with you to your next appointment.

- | | YES | NO |
|---|--------------------------|--------------------------|
| 1. Will you be thirty-five or older at your due date? | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Have you had an amniocentesis/ CVS before? | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. Has anyone in your family been referred for a genetic evaluation? | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. Do you or your partner have any health problem? | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. Are you or your partner of: | | |
| Jewish background? | <input type="checkbox"/> | <input type="checkbox"/> |
| Black or African background? | <input type="checkbox"/> | <input type="checkbox"/> |
| Asian background? | <input type="checkbox"/> | <input type="checkbox"/> |
| French - Canadian background? | <input type="checkbox"/> | <input type="checkbox"/> |
| 6. Have you taken any medications (prescription or over the counter) during this pregnancy? | <input type="checkbox"/> | <input type="checkbox"/> |
| 7. Have you used any street drugs during this pregnancy? | <input type="checkbox"/> | <input type="checkbox"/> |
| 8. During this pregnancy, have you taken Accutane, epilepsy medication, blood thinners, or lithium? | <input type="checkbox"/> | <input type="checkbox"/> |
| 9. Have you had radiation therapy, x-rays or chemotherapy since your last period? | <input type="checkbox"/> | <input type="checkbox"/> |
| 10. Have you or your partner been exposed to any hazardous chemicals or environmental toxins? | <input type="checkbox"/> | <input type="checkbox"/> |
| 11. Are you or your partner related in any other way other than be marriage (such as cousins, etc)? | <input type="checkbox"/> | <input type="checkbox"/> |
| 12. Have you, your partner or anyone in either family ever had: | | |
| A child with Down syndrome or other chromosome problems? | <input type="checkbox"/> | <input type="checkbox"/> |
| A child with mental retardation? | <input type="checkbox"/> | <input type="checkbox"/> |
| Open spine (spina bifida), skull defect or anencephaly? | <input type="checkbox"/> | <input type="checkbox"/> |
| Heart defect? | <input type="checkbox"/> | <input type="checkbox"/> |
| Muscle or neuromuscular disease (muscular dystrophy)? | <input type="checkbox"/> | <input type="checkbox"/> |
| Three or more miscarriages? | <input type="checkbox"/> | <input type="checkbox"/> |
| A still born baby? | <input type="checkbox"/> | <input type="checkbox"/> |
| A baby that died shortly after birth or in the first year? | <input type="checkbox"/> | <input type="checkbox"/> |
| Cystic fibrosis? - See reverse side- | <input type="checkbox"/> | <input type="checkbox"/> |
| Hemophilia sickle cell, thalassemia or other blood disorder? | <input type="checkbox"/> | <input type="checkbox"/> |
| Any birth defects or genetic disease not listed above? | <input type="checkbox"/> | <input type="checkbox"/> |

COMMENTS: _____

