

Prenatal Questionnaire

Patient Name _____

Birth Defects (including mental retardation) occur in about one in every twenty pregnancies. Some couples have a greater than average risk for having a child with a birth defect. Your answers to the following questions will help us determine if you are at increased risk. If you are unsure about a specific question, please discuss it with us before answering.

Your Ethnicity _____ Baby's Father Ethnicity _____
(Examples: Jewish, Black, Asian, Caucasian, Mediterranean, Greek, Italian, Turkish)

1. Have you ever had a miscarriage? Yes _____ No _____
2. Have you had a stillborn baby? Yes _____ No _____
3. Have any of your children died? Yes _____ No _____
4. If your baby's father has had children by other woman/women, did she/they have miscarriages, stillbirths, children who died, children with birth defects or children who are mentally retarded? Yes _____ No _____
5. Will you be 35 or older when your baby is due? Yes _____ No _____
6. Are you and the baby's father related to each other? Yes _____ No _____
7. Have you or the baby's father (or any close relatives in either of your families) had Downs Syndrome (mongolism), spina bifida (open spine), hemophilia, muscular dystrophy, cystic fibrosis, or mental retardation? Yes _____ No _____
8. Have you or the baby's father (or any close relatives in either of your families) had a child born dead or alive with a birth defect or genetic condition or inherited disorder not listed in question 7 above? Yes _____ No _____
9. Is there any condition, disease, disorder, or birth defect that is "genetic", "inherited", or "runs" in your family or in the family of the baby's father? Yes _____ No _____
10. Have you or the baby's father been screened for any of the following disorders: Tay Sachs _____ Sickle Cell _____ Thalassemia _____? Yes _____ No _____
11. Do you drink alcohol? Yes _____ No _____
12. Do you smoke? Yes _____ No _____
13. Since you became pregnant, have you taken any medications? (Prescription or those bought without prescription in any drug store or health food store) Yes _____ No _____
14. Since becoming pregnant have you used Accutane or Vitamin A in high doses? Yes _____ No _____

15. Have you used any drugs (for example: cocaine, marijuana, crack, speed) either before or after becoming pregnant? If so please list these: _____ Yes _____ No _____

16. Have you been on any special diets either before or during your pregnancy? Yes _____ No _____

17. Have you been exposed to x-rays or chemicals (at work or at home) during this pregnancy? Yes _____ No _____

18. Have you had a fever of 103°F or greater at any time during the first two months of your pregnancy? Yes _____ No _____

19. Have you or the baby's father ever had herpes? Yes _____ No _____

20. Have you ever had hepatitis? Yes _____ No _____

21. Do you have pets at home? If so please list: _____ Yes _____ No _____

22. Do you eat raw or uncooked meat? Yes _____ No _____

23. Testing of the AIDS virus is recommended for women who:

a. Have used drugs intravenously (injected themselves with drugs).

b. Were born in Haiti or Central Africa

c. Have received a blood transfusion

d. Are or have been sexual partners of IV drug abusers, homosexuals, bisexuals, men with hemophilia, men born in Haiti or Central Africa, men with AIDS or AIDS like symptoms.

e. At any time have had multiple sexual partners.

Do you belong to any of the above groups? Yes _____ No _____

24. Is your baby's father healthy? Yes _____ No _____

25. Does your baby's father take any medications or drugs regularly? Yes _____ No _____

26. Has your baby's father been exposed to x-rays, chemicals? Yes _____ No _____

27. How old is your baby's father? _____

Comments:

Date _____ Signature _____