Moustafa M. Hassan, M.D., Director, FACOG
Mohammed A. Elkousy, M.D., FACOG
Marquis Jessie, M.D., FACOG
Armin Razavi, M.D., FACOG

MFAMA
Maternal Fetal Associates
Of The Mid-Atlantic, LLC.

Accredited with the American Institute of Ultrasound in Medicine
and by the Fetal Medicine Foundation

PATIENT GENETIC SCREENING QUESTIONNAIRE

Please complete the following questionnaire so we can give you the best prenatal care. These questions regarding family health apply to members in both your family and in the baby's father's family. If you do not understand some of the questions, please mark them with a question mark and ask for help during your interview. Thank you.

Name: _____ Date: _____

First Day of Your Last Menstrual Period _____Estimated Due Date_____
Patient date of birth (xx/xx/xxxx) _____ Age at time of Delivery _____
Father of the baby date of birth (xx/xx/xxxx) _____

YES □ NO □ Have you or the baby's father in any previous relationships had 2 or more spontaneous pregnancy losses, a stillbirth, or neonatal death?
YES □ NO □ Is this pregnancy a result of In Vitro Fertilization (IVF) or Intra-uterine Insemination (IUI)?
YES □ NO □ Is this pregnancy a result of implantation with a donor egg or donor embryo?

Have you, the baby's father, or anyone in either of your families ever had any of the following?

YES □ NO □ Spina bifida or anencephaly (open spine or skull)?
YES □ NO □ Hemophilia or other bleeding disorder
YES □ NO □ Muscular dystrophy or other neuromuscular disorder
YES □ NO □ Down syndrome or other chromosomal abnormalities
YES □ NO □ Kidney disease
YES □ NO □ Mental retardation, developmental delay, or autism
YES □ NO □ Cystic fibrosis
YES □ NO □ Hydrocephalus (water on the brain)
YES □ NO □ Two or more relatives with the same cancer
YES □ NO □ Birth defect or inherited problem?
YES □ NO □ Deafness/early onset hearing loss
YES □ NO □ Blindness/early onset vision loss
YES □ NO □ Diabetes
YES □ NO □ PKU
YES □ NO □ Epilepsy or Lupus
YES □ NO □ Heart defect from birth
YES □ NO □ Have you or any female relative had an amniocentesis?
YES □ NO □ Are you or the baby's father of Jewish, French Canadian or Cajun ancestry?
YES □ NO □ Are you or the baby's father of Black or Latino ancestry?
If so, have either of you been screened for sickle cell? Results_____
YES □ NO □ Are you or the baby's father of Italian, Greek, Mediterranean, Asian Indian, Southeast Asian, Korean, Filipino, Chinese or Taiwanese ancestry?
YES □ NO □ Are you and the baby's father related in any way (cousins; for example)?

During this pregnancy, have you had any of the following?

YES □ NO □ uterine cramping, vaginal bleeding (spotting)
YES □ NO □ infections, rashes, fever (>101degrees)or other illness
YES □ NO □ X-rays, hospitalizations or surgery
YES □ NO □ Cigarettes, alcoholic beverages or "street" drugs
YES □ NO □ Occupational, chemical, or other exposures

Please explain any "yes" answers as well as any concerns you have about this baby, your pregnancy, your health, or your family history which are not mentioned above

_____

_____

_____

DOCTORS COMPLETE
I have discussed the questions answered yes with the patient and the patient wants genetic testing.
Date referred: _____ Genetic Center_____

PATIENT COMPLETE
If you do not want genetic counseling or testing, sign below:
I have discussed the questions which are answered "yes" with my physician and I understand that I have an increased risk for _____ and I know that it may be possible to diagnose an affected fetus, and I have decided **NOT** to have testing performed.

_____ _____ _____ _____
Patient Signature Date Witness Signature (office staff) Date