Center for Maternal and Fetal Medicine
Little Patuxent Specialty Care Center
11065 Little Patuxent Parkway Suite 100
Columbia, MD 21044
410-740-7903 – Appointments
410-720-8999 – FAX
410-740-7990 – TTY/DD

PATIENT GENETIC SCREENING FORM

NAME: Last: _____ First: _____

DATE OF BIRTH: _____

REFERRING PHYSICIAN: _____

IN YOUR OWN WORDS, WHY HAVE YOU BEEN REFERRED TO US?:

_____

BLOOD TYPE (If known): _____ RELIGION (optional): _____

LAST MENSTRUAL PERIOD (first day): _____

ARE YOU CURRENTLY PREGNANT? □ YES □ NO

DUE DATE (if currently pregnant): _____

TOTAL # OF PREGNANCIES: _____

Living children: _____ Preterm deliveries: _____

Miscarriages: _____ Voluntary terminations: _____

1. FAMILY HISTORY

Please check below if any of the following occurred in your families (siblings, parents, nieces/nephews, aunts/uncles, cousins, grandparents – living or deceased)

- ☐ Birth defects
- ☐ Infant or childhood deaths
- ☐ Mental retardation
- ☐ Muscular Dystrophy
- ☐ Blindness
- ☐ Deafness
- ☐ Dwarfism
- ☐ Hemophilia or bleeding disorder
- ☐ Thrombophilia (blood clotting disorder)
- ☐ Down syndrome
- ☐ Fragile X syndrome
- ☐ Emphysema (early onset, nonsmoker)
- ☐ Early onset cancer
- ☐ Other chromosome problem

  Specify: _____
- ☐ Congenital heart defect
- ☐ Spina bifida or anencephaly
- ☐ Cleft lip and/or palate
- ☐ Hydrocephalus (water on the brain)
- ☐ Cystic fibrosis
- ☐ Sickle cell disease or trait
- ☐ Thalassemia disease or carrier
- ☐ Tay-Sachs disease or carrier
- ☐ Phenylketonuria
- ☐ Huntington's disease
- ☐ Polycystic kidney disease
- ☐ Early onset heart disease
- ☐ Other metabolic disease

  Specify: _____
- ☐ Any other genetic conditions not listed

  Specify: _____

  _____

If you checked any of the above conditions, please indicate the person's relationship to you or the baby's father, the condition and the cause (if known):

_____

_____

_____

_____

_____

2. ETHNIC BACKGROUND

Please indicate the ethnic background of the following:

Patient: _____ Partner: _____

A. Do you have any of the following in your background?

	Patient	**Spouse/Partner**
1. Jewish/French Canadian	☐ Yes ☐ No	☐ Yes ☐ No
If yes, have you had carrier testing for Tay-Sachs disease, Canavan Disease, cystic fibrosis, Familial dysautonomia, Fanconi anemia (group C), Niemann-Pick (Type A), Bloom Syndrome, mucolipidosis IV and Gaucher disease (Type I)	☐ Yes ☐ No	☐ Yes ☐ No
If yes, please indicate results: _____		
2. Black/East Indian	☐ Yes ☐ No	☐ Yes ☐ No
If yes, have you had carrier testing for Sickle cell disease or another Hemoglobin variant?	☐ Yes ☐ No	☐ Yes ☐ No
If yes, please indicate results: _____		
3. Asian/Greek/Italian	☐ Yes ☐ No	☐ Yes ☐ No
If yes, have you had carrier testing for thalassemia?	☐ Yes ☐ No	☐ Yes ☐ No
If yes, please indicate results: _____		

B. **Have you had carrier screening for cystic fibrosis?** ☐ Yes ☐ No ☐ Yes ☐ No

If yes, please indicate results: _____

C. Have you had carrier screening for spinal muscular atrophy (SMA)?

☐ Yes ☐ No ☐ Yes ☐ No

If yes, please indicate results: _____

3. MATERNAL MEDICAL HISTORY

Please list any medical conditions, major surgeries and/or hospitalizations you have experienced throughout your life: _____

_____

_____

4. MATERNAL PAST PREGNANCY HISTORY

Please list all pregnancies (living, deceased, miscarriages, terminations). If any of these children have/had any medical conditions or learning difficulties, please specify in the column to the right.

Date of Birth	Sex	Full term vaginal delivery?	Father's Name	Specify

5. SPOUSE/PARTNER MEDICAL HISTORY

- Please list any medical conditions, major surgeries and/or hospitalizations that your spouse/partner have experienced throughout their life:_____

  _____

  _____

- Please list the sex and ages of your spouse/partner's children from any previous relationships (please specify any medical illnesses or learning difficulties):_____

  _____

  _____

6. CURRENT PREGNANCY (Skip this section if you are Pre-Conception)

- Are you having any complications (spotting, cramping, bleeding, etc.)?

  □ Yes □ No If yes, please list complications: _____

  _____

- Exposure to medications (prescription, over the counter), recreational drugs, herbal remedies?

  □ Yes □ No If yes, please give name(s), dosage and when taken:

  _____

- Do you currently smoke?

  □ Yes □ No If yes, please list amount and how often: _____

  _____

- Do you consume alcohol?

  □ Yes □ No If yes, please indicate the amount of alcohol you have had during this pregnancy and include gestational age at that time: _____

  _____

- Have you had any exposures to chemicals/pesticides/X-rays/cat litter boxes during this pregnancy?

  □ Yes □ No If yes, please list type, duration and gestational age at time of exposure:

  _____

- Have you had any exposure to infections during this pregnancy (fever, rash, etc.)

  □ Yes □ No If yes, please list type, duration and gestational age at time of exposure:

  _____

- Are you and the father of this pregnancy related by blood? □ Yes □ No
- Do you wish to know the sex of the baby? □ Yes □ No

7. FATHER OF THIS PREGNANCY: (Skip this section if you are Pre-Conception)

NAME: Last: _____ First: _____

DATE OF BIRTH: _____ RELIGION (Optional):_____