

Name of person completing survey: _____

Please complete the following survey. Mark **Yes or No** for each question. Provide comments when necessary.

| Yes | No | | Comments |
|-----|-----|---|----------|
| ___ | ___ | 1. Are you 34 years old or older? | _____ |
| ___ | ___ | 2. Is the father of your baby 55 years or older? | _____ |
| ___ | ___ | 3. Are you and the father of your baby blood relatives? | _____ |
| ___ | ___ | 4. Have you had a stillbirth or two or more miscarriages? | _____ |
| ___ | ___ | 5. Do you have diabetes? What age diagnosed? | _____ |
| ___ | ___ | 6. If yes to #5, are you taking insulin? | _____ |
| ___ | ___ | 7. Do you have seizures or epilepsy? | _____ |
| ___ | ___ | 8. Do you have any other medical conditions? | _____ |
| ___ | ___ | 9. What is your race? | _____ |
| ___ | ___ | 10. What countries are your ancestors from originally? (Be specific- i.e. England, Africa, Vietnam, etc) | _____ |
| | | Myself | _____ |
| | | Father of baby | _____ |
| ___ | ___ | 11. Are either of you Jewish, French Canadian, or Cajun? | _____ |
| ___ | ___ | 12. Have you had the Alpha-Feto protein (AFP) blood test or the triple screen blood test? If so, when? | _____ |



Do you or the father of your baby:

| | | | |
|-----|-----|---|-------|
| ___ | ___ | 1. Have any birth defects, handicapping conditions or disorder that might be hereditary? | _____ |
| ___ | ___ | 2. Have any previous children with birth defects, handicaps, or genetic diseases? | _____ |
| ___ | ___ | 3. Have any children who died (other than accident)? | _____ |
| ___ | ___ | 4. Have a brother, sister, or parent with a handicap, birth defect or genetic disease? | _____ |
| ___ | ___ | 5. Have any uncles, aunts, cousins, grandparents, nephews or nieces with a handicap, birth defects or genetic diseases? | _____ |
| ___ | ___ | 6. Know of any family member with mental retardation (even mild) or learning disabilities? | _____ |
| ___ | ___ | 7. Have any family members who have had multiple miscarriages (two or more) or a stillbirth? | _____ |

Patient Signature

Date

Please check any of the following that might be in either your family or the father of the baby's family and indicate who in the family is affected.

- | | |
|---|--|
| <input type="checkbox"/> Anencephaly (open skull) | <input type="checkbox"/> Kidney disease (i.e. Polycystic kidney) |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Limb defects (arms, legs) |
| <input type="checkbox"/> Blindness | <input type="checkbox"/> Mental illness |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Mental retardation |
| <input type="checkbox"/> Chromosome abnormalities | <input type="checkbox"/> Muscular/Myotonic Dystrophy |
| <input type="checkbox"/> Cleft lip/palate | <input type="checkbox"/> Neurofibromatosis |
| <input type="checkbox"/> Cystic fibrosis | <input type="checkbox"/> Neurologic or degenerative disorder |
| <input type="checkbox"/> Deafness | <input type="checkbox"/> Phenylketonuria (PKU) |
| <input type="checkbox"/> Down syndrome | <input type="checkbox"/> Sickle cell anemia |
| <input type="checkbox"/> Epilepsy or seizures | <input type="checkbox"/> Skeletal problems (easily broken bones or dwarfism) |
| <input type="checkbox"/> Heart defect | <input type="checkbox"/> Skin disease (including dark or light patches) |
| <input type="checkbox"/> Hemophilia (bleeding disorder) | <input type="checkbox"/> Spina bifida (open spine) |
| <input type="checkbox"/> Huntington's Chorea | <input type="checkbox"/> Thalassemia (Alpha or Beta) |
| <input type="checkbox"/> Hydrocephalus (water on the brain) | <input type="checkbox"/> Urinary tract disease |
| <input type="checkbox"/> Birth defects or inherited disorders not listed above- _____ | |
| <input type="checkbox"/> None of the above | |



ENVIRONMENTAL EXPOSURES HISTORY

- | Yes | No | Have you..... |
|--------------------------|--------------------------|---|
| <input type="checkbox"/> | <input type="checkbox"/> | 1. Taken any prescription drugs or over the counter medications since becoming pregnant? List- _____ Circle any that may apply: Accutane, Epilepsy medicines, Lithium, Blood thinner (anti-clot), etc. |
| <input type="checkbox"/> | <input type="checkbox"/> | 2. Had any illness or infections during pregnancy? List- _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | 3. Had a fever over 101 degrees or taken sauna or whirlpool baths during pregnancy? _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | 4. Had x-rays or surgery since becoming pregnant? Specify- _____ When? _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | 5. Had alcohol during your pregnancy? Specify how much and when - _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | 6. Smoked during your pregnancy? Specify how much and when- _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | 7. Used any other drugs during your pregnancy? Specify how much and when- _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | 8. Taken vitamins, supplements or herbal preparations this pregnancy? List- _____ |

Anything else not mentioned above or comments you would like to make about your answers to any of the questions on this form?

Patient Signature

Date