MATERNAL-FETAL MEDICINE ASSOCIATES
GENETIC AND MEDICAL HISTORY QUESTIONNAIRE

NAME:_____ SSN:_____ DOB:_____ DATE:_____

YES	NO		COMMENTS
____	____	1. Are you 34 years 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 stillborn or more than one miscarriage?	_____
____	____	5. Do you have diabetes?	_____
____	____	6. Are you insulin dependent?	_____
____	____	7. Do you have any other medical conditions for which you receive(d) treatment?	_____
____	____	8. What countries are your ancestors from originally? Myself	_____
____	____	(Be specific- i.e.: England, Africa, Vietnam) Father of Baby	_____
____	____	9. Are either of you Jewish, French Canadian or Cajun?	_____
____	____	10. Have you had the expanded AFP Blood Test? If so, when? (triple test; quad test)	_____

Do you or the father of your baby:

____	____	11. Have any birth defects, handicapping condition or disorder that might be hereditary?	_____
____	____	12. Have any previous children with birth defects, handicaps, or genetic disease?	_____
____	____	13. Have any children who died (other than accidental)?	_____
____	____	14. Have a brother, sister, or parent with a handicap birth defect or genetic disease?	_____
____	____	15. Have any uncles, aunts, cousins, grandparents, nephews, or nieces with birth defects or genetic disorders?	_____

____ ____ 16. Know of any family member with mental retardation (even mild) or learning disabilities? _____

____ ____ 17. Have any family members who have had multiple miscarriages or a stillbirth? _____

Please check any of the following that might be in either of your families and indicate who in the family is affected.

_____	Anencephaly	_____	Kidney disease (i.e. polycystic kidney)
_____	Anemia	_____	Limb defects
_____	Blindness	_____	Mental Illness
_____	Cancer	_____	Mental Retardation
_____	Chromosome abnormality	_____	Muscular Dystrophy/Myotonic Dystrophy
_____	Cleft lip/palate	_____	Neurofibromatosis
_____	Cystic Fibrosis	_____	Neurologic or degenerative disorder
_____	Deafness	_____	Phenylketonuria (PKU)
_____	Down Syndrome	_____	Sickle Cell Anemia
_____	Epilepsy or seizures	_____	Skeletal problems (like easily broken bones or dwarfism)
_____	Heart Defect	_____	Skin disease (including dark or light patches of skin)
_____	Hemophilia (bleeding tendency)	_____	Spina bifida (open spine)
_____	Huntington's Chorea	_____	Thalassemia (Mediterranean anemia)
_____	Hydrocephalus	_____	Urinary tract disease

Birth defects or inherited disorders not listed above _____

_____

_____ None of the above

Environmental Exposures History

Yes No Have you:

____ ____ Taken any prescription drugs, herbal, or over-the-counter medications since becoming pregnant?
Circle any that apply: Accutane, Epilepsy medication, Lithium, Blood thinner (anti-clotting)
Please list all medications that you have taken since becoming pregnant: _____
_____

____ ____ Had an illness or infection during pregnancy?

____ ____ Had a fever over 101 degrees or taken saunas or whirlpool baths during pregnancy?

____ ____ Had x-rays or surgery since becoming pregnant?

____ ____ Had alcohol during your pregnancy?

____ ____ Smoked during your pregnancy?

____ ____ Used any other drugs during your pregnancy?

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

_____
_____
_____
_____

Medical History

Please circle all that apply

Do you have any medical illnesses? Yes No

Diabetes, Hypertension, Heart Disease, Autoimmune Disorder, Kidney Disease, Urinary Tract Infections, Neurologic Disease, Epilepsy, Lung disease, Asthma, Psychiatric Illness, Liver Disease, Hepatitis, Varicose Veins, Phlebitis, Thyroid Disease, Trauma, Domestic Violence, Back Disease, History of Blood Transfusion.
Other: _____

Medical History

Please circle all that apply

Have you ever undergone a minor or major surgical procedure? Yes No

Please list all surgical procedures which you have undergone:

_____

_____

_____

Do you have any implantable devices? Yes No Pacemaker, Prosthetic Heart Valve, Prosthetic Joints

Please list all implantable devices:

_____

_____

_____

Do you have any allergies? Yes No Medications, Contrast Media, Iodine, Intravenous Solutions Latex, Animals, Chemicals

Please list all allergies:

_____

_____

_____