



General Information

Reason for your referral to our center _____

Mother of the Pregnancy

Name _____
 DOB _____ Age _____
 Religion _____
 Occupation _____
 Please list any surgeries or chronic illnesses _____

Father of the Pregnancy

Name _____
 DOB _____ Age _____
 Religion _____
 Occupation _____
 Please list any surgeries or chronic illnesses _____

Please list any medication allergies _____

Marital status (circle one):

Entered into EMR

single married widowed

Pregnancy History

Please list all children, living or deceased, for you or the father of the pregnancy.

NAME	AGE	SEX	MAJOR HEALTH PROBLEMS	RELATED TO MOTHER ONLY	RELATED TO FATHER ONLY

Have you had any miscarriages or ectopic (tubal) pregnancies? Yes No

If yes, please provide the following information if known

YEAR	GESTATIONAL AGE	CAUSE

Have you had any stillborn (dead at birth) infants? Yes No

If yes, please provide information regarding the cause if known _____

Current Pregnancy

Do you want to know the sex of the baby? Yes No

List any medications taken during this pregnancy (prescription, over-the-counter and recreational drugs)

NAME	DOSE	WHEN STARTED	WHEN STOPPED



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 QUESTIONNAIRE**

3-Hole 5/16 4 1/4 c-to-c

5/1

5/1

Current Pregnancy (continued)

How much alcohol has been consumed during this pregnancy? _____

How much have you smoked during this pregnancy?

Have you had any x-ray exposure? _____

Please list all chemical, radiation, occupational, or other exposures you may have had during this pregnancy

Have you had any spotting, bleeding or other complications of pregnancy? Yes No

If yes, please describe _____

Have you had any illnesses, fever or infections other than yeast? Yes No

If yes, please describe _____

Family History

Are you and the father of the pregnancy related by blood (i.e. first cousins)? Yes No

If yes, how are you related? _____

Is there any history of the following in either your family or in the father of the pregnancy's family?

	MOTHER OF PREGNANCY		FATHER OF PREGNANCY		IF YES, DESCRIBE
	NO	YES	NO	YES	
Bleeding Disorder (i.e. Hemophilia)					
Blindness					
Cancer					
Chromosome Abnormality (i.e. Down Syndrome)					
Cleft Lip and/or Palate					
Cystic Fibrosis					
Deafness					
Epilepsy or Seizure Disorder					
Heart Defect (from birth)					
Hydrocephalus					
Kidney Disease					
Mental Retardation					
Multiple Miscarriages or Stillbirths					
Muscular Dystrophy					
Neural Tube Defects (Anencephaly, Spina Bifida)					
Sickle Cell Anemia or Trait					
Tay-Sach's Disease					
Thalassemia					
Other Birth Defect or Genetic Disease					



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