

Prenatal Screening Questionnaire Name \_\_\_\_\_ Date \_\_\_\_\_

\*\* If you are uncomfortable answering any questions, leave them blank; you can discuss them with the nurse or doctor

Family and Genetic

1. Will you be 35 years or older when the baby is born? yes no
2. Will the father be 50 years or older? yes no
3. Have you or the baby's father had a child born with a birth defect? yes no
4. Did either you or the baby's father have a birth defect? yes no
5. Some genetic problems occur more in couples with certain racial or ancestral backgrounds. Please note if you or the baby's father is
  - a. Eastern European Jewish ancestry yes no  
 If yes, have you had Tay-Sachs screening?  
 Date \_\_\_\_\_ Results \_\_\_\_\_
  - b. African American yes no  
 If yes, have you had sickle cell screening?  
 Date \_\_\_\_\_ Results \_\_\_\_\_
  - c. European Ancestry yes no  
 If yes, have you had cystic fibrosis screening?  
 Date \_\_\_\_\_ Results \_\_\_\_\_
  - d. Mediterranean or Southeast Asian Ancestry yes no  
 If yes, have you had screening for inherited anemia such as thalassemia?  
 Date \_\_\_\_\_ Results \_\_\_\_\_
6. Please describe any abnormalities in children of your family or the baby's father's family (eg Mental retardation, birth defects, deformities, or inherited diseases such as hemophilia, muscular dystrophy, or cystic fibrosis): \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_
7. Do you or the baby's father have a history of miscarriages or stillbirths? yes no
  - a. If yes, have either of you had genetic counseling? yes no
  - b. If yes, have either of you had chromosomal testing? yes no  
 Date \_\_\_\_\_ Results \_\_\_\_\_

Gynecologic

1. When was your last Pap smear? \_\_\_\_\_  
 Have you ever had an abnormal Pap smear? yes no  
 What was the diagnosis? \_\_\_\_\_  
 When and how were you treated? \_\_\_\_\_
2. Have you ever had: gonorrhea chlamydia pelvic inflammatory disease yes no  
 If yes, when, how, and where were you treated? \_\_\_\_\_
3. Have you ever had herpes? yes no  
 If yes, how often do you have an outbreak? \_\_\_\_\_
4. Have you ever had syphilis? yes no  
 If yes, when, how, and where were you treated? \_\_\_\_\_
5. What forms of contraception have you used in the past? \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_
6. Have you ever been treated for infertility? yes no  
 If yes, please describe when and the treatment received: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

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Social

- |  |     |    |
|--|-----|----|
| 1. Do you smoke cigarettes?<br>If yes, how many packs per day? _____   | yes | no |
| 2. Do you drink alcohol (including beer, wine, and mixed drinks)?<br>If yes, what and how often? _____   | yes | no |
| 3. Please list any medications you have taken since your last period, including prescription, over the counter, vitamin, herbal and supplements.<br>_____<br>_____ |     |    |
| 4. Please list any recreational or illicit drugs used in the last six months.<br>_____<br>_____  |     |    |
| 5. Are you exposed to any chemicals that concern you?<br>If yes, please explain. _____   | yes | no |
| 6. Do you follow any special diet (eg vegetarian, diabetic, restricted)?<br>If yes, please explain. _____  | yes | no |
| 7. Do you participate in regular exercise or physical activity?<br>If yes, please describe. _____  | yes | no |
| 8. In the past year, have you been threatened, hit, or kicked by anyone you know?  | yes | no |
| 9. Has anyone forced you to perform any sexual act that you did not want?  | yes | no |
| 10. On a scale of 1-5, how do you rate your current stress level?<br>Low    1    2    3    4    5    High  |     |    |
| 11. If you could change the timing of this pregnancy, would you want it<br>Earlier                  Later                  Not at all                  No change   |     |    |