OB SCREENING QUESTIONNAIRE

Patient Name__________________________ **DOB**__________________ **Chart #**________________

1. Will you be age 35 or older when you have children? _____YES _____NO

2. Have you or your partner or anyone in either of your families ever had
   Down's syndrome (Mongolism)? _____YES _____NO
   Spina bifida or meningomyelocele (open spine)? _____YES _____NO
   Hemophilia? _____YES _____NO
   Muscular dystrophy? _____YES _____NO
   Cystic fibrosis _____YES _____NO

3. Have you or your partner had a child born dead or alive with a birth defect not listed in Question 2 above? _____YES _____NO
   If yes, describe:____

4. Do you or your partner have any close relatives who are mentally retarded or have birth defects? _____YES _____NO
   If yes, list cause if known:____

5. Do you or your partner or a close relative in either of your families have any inherited genetic or chromosomal disease or disorder not listed above? _____YES _____NO
   If yes, describe:____

6. Have you or your partner had 3 or more spontaneous pregnancy losses (miscarriages, stillbirths, etc.)? _____YES _____NO

7. Do you or your partner have any close relatives descended from Jewish people who lived in Eastern Europe (Ashkenazi Jews)? _____YES _____NO
   If yes, have either your or your partner been screened for Tay-Sachs disease? _____YES _____NO
   If yes, indicate results and who was screened:_____________________________________

8. Are you or your partner African American? _____YES _____NO
   If yes, have either you or your partner, or any close relative ever been screened for sickle cell trait and found to be positive? _____YES _____NO
   If yes, indicate results and who was screened:_____________________________________

9. Do you or your partner have any close relatives descended from Mediterranean countries? _____YES _____NO
   If yes, have you, or your partner, been screened for thalassemia (Cooley's Anemia)? _____YES _____NO

10. Do you drink alcoholic beverages? _____YES _____NO
    If yes, describe how often and amount:____

11. Do you take any medications either by prescription or those which can be purchased over the counter in a drug store? _____YES _____NO
    If yes, please list drugs and dosage schedule:______________________________________

12. Have you ever been tested to determine if you are immune to rubella (German Measles)? _____YES _____NO
    If yes, indicate where and when tested and results of test:_____________________________