

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 you or your partner been screened for Tay-Sacs 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: _____
13. Do you have an Advanced Directive or a Living Will? Yes No
If no and you would like one, please contact our medical records supervisor.