

# Women's Specialists Of Plano, L.L.P.

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## PRENATAL DIAGNOSIS QUESTIONNAIRE

PATIENT NAME: \_\_\_\_\_ DOB: \_\_\_\_\_ Date of last period: \_\_\_\_\_

Birth defects (including mental retardation) occur in about one in every twenty pregnancies. Some couples have a greater than average risk of having a child with a birth defect. Your answers to the following questions will help us determine if you are at an **INCREASED** risk. If you are unsure about a specific question, please discuss it with us before answering.

- 1) Have you ever been pregnant? If yes, how many times? \_\_\_\_\_  yes  no
- 2) Have you ever had a miscarriage? If yes, when? \_\_\_\_\_  yes  no
- 3) Have you had a stillborn baby?  yes  no
- 4) Have any of your children died?  yes  no
- 5) If your baby's father has had children by another woman/other women, did she/they have miscarriages, stillbirths, children who died, children with birth defects or children who are mentally retarded?  yes  no
- 6) Will you be 35 or older when your baby is due?  yes  no
- 7) Are you and the baby's father related to each other? (1st cousins, 2nd cousins, etc)  yes  no
- 8) Have you or the baby's father (or any close relatives in either of your families) had Down's syndrome (mongolism), spina bifida (open spine), hemophilia, muscular dystrophy, cystic fibrosis, or mental retardation?  yes  no
- 9) Have you or the baby's father (or any close relatives in either of your families) had a child born dead or alive with a birth defect or genetic condition or inherited disorder not listed in question 7 above?  yes  no
- 10) Is there any condition, disease, disorder, or birth defect that is "genetic, inherited or runs" in your family or in the family of the baby's father?  yes  no
- 11) Are you or the baby's father from any of the following backgrounds: Jewish, Black, Asian, Mediterranean, (Greek, Italian, Turkish)?  yes  no
- 12) Have you or the baby's father been screened for any of the following disorders: Tay Sachs \_\_\_\_\_, Sickle Cell \_\_\_\_\_, Thalassaemia \_\_\_\_\_?  yes  no
- 13) Do you drink alcohol?  yes  no
- 14) Do you smoke?  yes  no
- 15) Since you became pregnant, have you taken **ANY** medications? (prescriptions or those bought without a prescription in any drug store or health food store)  yes  no
- 16) Since becoming pregnant, have you used Accutane or taken Vitamin A in high doses?  yes  no
- 17) Have you used any drugs (for example, cocaine, marijuana, crack, speed) either before or after becoming pregnant? If so please list: \_\_\_\_\_  yes  no
- 18) Have you been on any special diets either before or during your pregnancy?  yes  no
- 19) Have you been exposed to x-rays or chemicals (at work or at home) during this pregnancy?  yes  no
- 20) Have you have a fever of 103 degrees or greater during the first two months of your pregnancy?  yes  no
- 21) Have you or the baby's father ever had Herpes?  yes  no
- 22) Have you ever had hepatitis?  yes  no
- 23) Do you have pets at home? If so, please list \_\_\_\_\_  yes  no
- 24) Do you eat raw or uncooked meat?  yes  no
- 25) As part of your routine prenatal blood tests and in compliance with Texas House Bill #1345. Your blood will be screened for the HIV virus, unless you refuse this test.  I refuse the HIV screen \_\_\_\_\_  
(Initial)

COMMENTS: \_\_\_\_\_

Date: \_\_\_\_\_ PATIENT'S SIGNATURE \_\_\_\_\_