Pacific Women's Center
Physicians and Surgeons

Prenatal Genetic Screen

Name: _____ Date: _____

Birth date: _____

		Please Check: Yes	No
1.	Will you accept blood products for life saving measures?	1.	
2.	Will you be 35 years or older when the baby is due?	2.	
3.	Do you have sickle cell disease or trait?	3.	
4.	Do you have Thalassemia or are you of Italian, Greek, Mediterranean, or Asian descent?	4.	
5.	Have you or the baby's father or anyone in your families had:	5.	
	a. Tay-Sachs	a.	
	b. Down Syndrome	b.	
	c. Intellectual Disability	c.	
	d. If yes, was the person tested for Fragile X Syndrome?	d.	
	e. Neural Tube defect	e.	
	f. Cystic Fibrosis	f.	
	g. Huntington Chorea	g.	
	h. Muscular dystrophy	h.	
	i. Hemophilia	i.	
	j. Congenital Heart Defect	j.	
	k. Other inherited conditions	k.	

If yes, indicate the relationship of the affected person to you or the baby's father: _____

6.	Has the father of the baby had a child with other birth defects?	6.	
7.	Are you or the father of Ashkenazi Jewish descent?	7.	
8.	Do you live with someone who has Tuberculosis or are you exposed to Tuberculosis?	8.	
9.	Do you or does your partner have a history of genital herpes?	9.	

(Over →)

		Please Check: Yes	No
10. Have you had a rash or viral illness since your last period?	10.		
11. Do you have any history of Sexually Transmitted Infection (Syphilis, Gonorrhea, Chlamydia, HPV)?	11.		
12. Have you or your partner travelled to any Zika Virus endemic area within the past 6 months? (i.e. Caribbean, Africa, South America, Mexico, Asia)	12.		
13. Have you ever had Chicken Pox?	13.		
14. Any other genetically-transmissible disorders?	14.		