



## PRENATAL GENETIC QUESTIONNAIRE

NAME: \_\_\_\_\_ DOB: \_\_\_\_\_

### MATERNAL AGE

1. Will you be 35 years or older when the baby is due? YES \_\_\_\_\_ NO \_\_\_\_\_

### GENETIC DISEASES COMMON TO CERTAIN ETHNIC GROUPS

1. Are you or the baby's father of African descent? YES \_\_\_\_\_ NO \_\_\_\_\_  
If yes, have either of you been screened for sickle cell trait? YES \_\_\_\_\_ NO \_\_\_\_\_
2. Are you or the baby's father of Eastern European Jewish descent? YES \_\_\_\_\_ NO \_\_\_\_\_  
If yes, have either of you been screened for Tay-Sach's disease? YES \_\_\_\_\_ NO \_\_\_\_\_
3. Do you or the baby's father have any close relatives from Italy, Greece or other Mediterranean countries? YES \_\_\_\_\_ NO \_\_\_\_\_  
If yes, have either of you been screened for beta-thalassemia? YES \_\_\_\_\_ NO \_\_\_\_\_
4. Do you or the baby's father have any close relatives from the Philippines or Southeast Asia? YES \_\_\_\_\_ NO \_\_\_\_\_  
If yes, have either of you been screened for alpha-thalassemia? YES \_\_\_\_\_ NO \_\_\_\_\_

### PERSONAL AND FAMILY GENETIC HISTORY

1. Have you, the baby's father or any member of you respective family ever had any of the following disorders?

- |  |                    |
|--|--------------------|
| Down Syndrome  | YES _____ NO _____ |
| Other chromosomal abnormalities  | YES _____ NO _____ |
| Congenital heart defects   | YES _____ NO _____ |
| Hemophilia   | YES _____ NO _____ |
| Muscular Dystrophy   | YES _____ NO _____ |
| Cystic Fibrosis (CF)   | YES _____ NO _____ |
| Spina Bifida (open spine), hydrocephaly (water on the brain) or anencephaly (absent brain) | YES _____ NO _____ |
| A genetic disorder or birth defect not listed above  | YES _____ NO _____ |
| Please list here _____   |                    |

If the answer is yes to any of the above, what is the relationship of the family member to you? \_\_\_\_\_

2. Do you or the baby's father have a birth defect? YES \_\_\_\_\_ NO \_\_\_\_\_  
If yes, please describe \_\_\_\_\_
3. Have you ever had a baby who died in the womb? YES \_\_\_\_\_ NO \_\_\_\_\_
4. Have you ever had a baby with a birth defect? YES \_\_\_\_\_ NO \_\_\_\_\_
5. Have you ever had three or more miscarriages before 12 weeks pregnant? YES \_\_\_\_\_ NO \_\_\_\_\_
5. Excluding prenatal vitamins, have you ever taken any medication during pregnancy? YES \_\_\_\_\_ NO \_\_\_\_\_  
If yes, please list \_\_\_\_\_
7. Have you ever used any "recreational drugs" (alcohol, marijuana, cocaine, heroine, etc.) during pregnancy? YES \_\_\_\_\_ NO \_\_\_\_\_

### MASFP/hCG SCREENING

MATERNAL SERUM ALPHA-FETOPROTEIN (MSAFP) AND HUMAN CHORIONIC GONADOTROPIN (hCG) SCREENING IS OFFERED TO ALL PREGNANT WOMEN TO DETERMINE IF THEIR FETUS IS AT INCREASED RISK FOR A NEURAL TUBE DEFECT (NTD), ABDOMINAL WALL DEFECT (AWD), OR DOWN SYNDROME. IT IS BLOOD DRAWN FROM YOUR ARM BETWEEN 15-18 WEEKS GESTATION.

1. NTD: IS A SERIOUS BIRTH DEFECT CAUSED BY FAILURE OF SKULL CLOSURE (ANENCEPHALY-ALETHAL BIRTH DEFECT) OR SPINAL COLUMN CLOSURE (SPINA BIFIDA). THE LATTER VARIES IN DEGREES OF SEVERITY. MSAFP SCREENING CAN DETECT APPROXIMATELY 85% OF FETAL OPEN NTD'S.
2. AWD: REFERS TO A PROTRUSION OF ABDOMINAL CONTENTS OUTSIDE THE FETAL ABDOMEN. MSAFP SCREEN CAN DETECT APPROXIMATELY 80% OF FETAL AWD'S.
3. DOWN SYNDROME: A CHROMOSOMAL CONDITION WITH RECOGNIZABLE FACIAL FETAURES, MENTAL RETARDATION, AND OCCASIONAL PHYSICAL BIRTH DEFECTS REQUIRING SURGICAL REPAIR. MSAFP SCREENING CAN DETECT APPROXIMATELY 50% OF DOWN SYNDROME.

THIS TEST IS ONLY **SCREENING** AND IS NOT DIAGNOSTIC OF THESE DISORDERS. OVER 90% OF WOMEN WITH INFANTS BORN WITH THESE DISORDERS DO NOT HAVE A FAMILY HISTORY, THERE FORE THE MSAFP MAYBE USEFUL TO HELP DETECT THESE DIORDERS. THERE IS A 40% CHANCE OF THE TEST COMING BACK POSITIVE AND THERE IS NOTHING WRONG WITH THE BABY. SO AN ABNORMAL MSAFP DOES NOT MEAN THAT YOUR BABY HAS A PROBLEM. IT COULD MEAN THAT YOUR DUE DATE IS WRONG, TWINS, IMPENDING MISCARRIAGE OR FOR NO OBVIOUS REASON. AN ULTRASOUND AND/OR AN AMNIOCENTESIS WITH GENETIC COUNSELING MAY BE OFFERED TO DIAGNOSE A DISORDER.

WHEN DECIDING WHETHER TO GET THIS SCREENING OR NOT YOU MAY ASK YOURSELF "DO I WANT TO KNOW ABOUT THESE BIRTH DEFECTS IN MY BABY BEFORE DELIVERY? HOW WILL I RESPOND TO THE RESULTS?"

- \_\_\_\_\_ YES: I **REQUEST** THE INTEGRATED AFP BE DONE SEE BOOKLET FOR DETAILS (IN OFFICE)  
(THE ABOVE TEST NEEDS TO BE DONE PRIOR TO 12 WEEKS OF PREGNANCY)
- \_\_\_\_\_ YES: I **REQUEST** THAT BLOOD BE DRAWN FOR THE MSAFP/hCG SCREENING TEST
- \_\_\_\_\_ NO: I **DO NOT** WANT THE ABOVE TEST(S)  
PERFORMED

SIGNED: \_\_\_\_\_ DATE: \_\_\_\_\_

### ULTRASOUND

ULTRASOUND EXAMINATION IS NOT CURRENTLY A STANDARD PART OF OBSTETRICAL CARE IN THE UNITED STATES.

ULTRASOUND CAN BE USEFUL IN TH E CONFIRMING YOUR DUE DATE, PLACENTAL POSITION, NUMBER OF FETUSES AND SOME FETAL ANATOMY. FURTHERMORE IT HAS NOT BEEN SHOWN TO INCREASE THE RISK OF BIRTH DEFECTS WHEN USED DURING PREGNANCY. YOU SHOULD CONSIDER ULTRASOUND EXAMINATION WHEN RECOMMENDED BY YOUR CNM.

- \_\_\_\_\_ YES: I **DO** WANT A ROUTINE ULTRASOUND BETWEEN 18-20 WEEKS GESTATION.
- \_\_\_\_\_ NO: I **DO NOT** WANT A ROUTINE ULTRASOUND.

SIGNED: \_\_\_\_\_ DATE: \_\_\_\_\_

REVISED 5/09