

GENETIC SCREENING

CHILDREN (LIVING/DECEASED)

NAME(S) OF CHILD(REN)	AGE	SEX	NATURAL FATHER'S NAME	NATURAL MOTHER'S NAME	MEDICAL ILLNESS OR SURGERY
_____					Yes No
_____					Yes No
_____					Yes No
_____					Yes No

#PREGNANCIES _____ #LIVEBIRTHS _____ #STILLBIRTHS _____ #MISCARRIAGES _____

Are you and the father of this pregnancy blood relatives? Yes No
 Is there inherited or genetic disease in either of your families? Yes No
 Has there been pregnancy x-ray or medication exposure during pregnancy? Yes No

IF ANY OF THE FOLLOWING OCCURRED IN YOUR FAMILIES (i.e., GRANDPARENTS, PARENTS, CHILDREN, SISTERS, BROTHERS AND DESCENDANTS LIVING OR DECEASED), PLEASE CHECK BELOW. ON THE BACK, DESCRIBE COMPLETELY AND SHOW WITH A PEDIGREE (FAMILY TREE TRACED TO THIS PREGNANCY) WHICH SIDE OF THE FAMILY.

- | | | |
|---|---|--|
| <input type="checkbox"/> BIRTH DEFECTS
<input type="checkbox"/> INFANT OR CHILDHOOD DEATHS
<input type="checkbox"/> MENTAL RETARDATION
<input type="checkbox"/> DOWN SYNDROME (MONGOLISM)
<input type="checkbox"/> TAY-SACHS CARRIER
<input type="checkbox"/> HYDROCEPHALUS (Water on the Brain)
<input type="checkbox"/> MUSCULAR DYSTROPHY
<input type="checkbox"/> EARLY ONSET (<35) EMPHYSEMA
<input type="checkbox"/> HEMOPHILIA OR BLEEDING DISORDER
ANY OTHER INHERITED OR GENETIC CONDITIONS _____ | <input type="checkbox"/> HUNTINGTON'S CHOREA
<input type="checkbox"/> CLEFT LIP OR PALATE
<input type="checkbox"/> DEAFNESS
<input type="checkbox"/> DWARFISM
<input type="checkbox"/> SPINA BIFIDA
<input type="checkbox"/> SICKLE CELL TRAIT
<input type="checkbox"/> GALACTOSEMIA
<input type="checkbox"/> EARLY ONSET (<35) CANCER | <input type="checkbox"/> ACUTE INTERMITTENT PROPHYRIA
<input type="checkbox"/> BLINDNESS
<input type="checkbox"/> CONGENITAL HEART DISEASE
<input type="checkbox"/> POLYCYSTIC KIDNEY DISEASE
<input type="checkbox"/> CYSTIC FIBROSIS
<input type="checkbox"/> THALASSEMIA TRAIT
<input type="checkbox"/> EARLY ONSET (<35) HEART DISEASE
<input type="checkbox"/> PHENYLKETONURIA (PKU) |
|---|---|--|

MOTHER OF CHILD ARE YOU:

JEWISH? YES NO
 RESULTS OF TAY-SACHS TESTING & DATE OF TEST: _____

BLACK/EAST INDIAN? YES NO
 RESULTS OF SICKLE CELL TESTING & DATE OF TEST: _____

GREEK/ITALIAN? YES NO
 RESULTS OF THALASSEMIA CARRIER TESTING & DATE OF TEST: _____

I AM NOT IN ONE OF THE ABOVE ETHNIC GROUPS.
 I AM IN ONE OF THE ABOVE CATEGORIES AND WILL HAVE TESTING. DATE _____
 I DECLINE TESTING.

FATHER OF CHILD ARE YOU:

JEWISH? YES NO
 RESULTS OF TAY-SACHS TESTING & DATE OF TEST: _____

BLACK/EAST INDIAN? YES NO
 RESULTS OF SICKLE CELL TESTING & DATE OF TEST: _____

GREEK/ITALIAN? YES NO
 RESULTS OF THALASSEMIA CARRIER TESTING & DATE OF TEST: _____

I AM NOT IN ONE OF THE ABOVE ETHNIC GROUPS.
 I AM IN ONE OF THE ABOVE CATEGORIES AND WILL HAVE TESTING. DATE _____
 I DECLINE TESTING.

DO YOU HAVE ANY OTHER CONCERNS NOT COVERED ABOVE? YES (SPECIFY BELOW) NO

CONSENT TO AIDS SCREENING? YES NO

SIGNATURE OF PATIENT: _____ DATE: _____