FIRST PHYSICIANS GROUP
of Sarasota Memorial Health Care System

Maternal Fetal Medicine Genetic Health History Questionnaire

Name: _____

Date of Birth: ____/_____/_____ How old will you be when the baby is born? _____

Partner's Name: _____ Partner's Date of Birth: ____/_____/_____

Medications: Please list any medications that you take including over the counter and supplements		
Medication	**Dose**	**How Often?**

Are you or your partner from any of the following ethnic backgrounds?		
Location	**Yes**	**No**
Chinese, Taiwanese, Filipino, or Southeastern Asia		
Italian, Greek, or Middle Eastern		
Eastern European (Ashkenazi) Jewish		
French, Canadian, or Cajun		

Health screening questions:		
Have you used street drugs since your last menstrual period?		
Have you consumed alcoholic drinks since your last menstrual period?		
Have you used any tobacco products since your last menstrual period?		
Do you have Diabetes (gestational, type 1 or 2)?		
Have you developed any rashes, infections, or fevers since pregnant		
Have you been exposed to an X-Ray?		
Have you participated in reproductive technology (IUI, IVF, ICSI, PGD, donor)?		
Have you had carrier testing for cystic fibrosis?		
Have you had carrier testing for any other genetic disorder?		
Have you had blood chromosome testing?		
Are you or your partner adopted?		

Have you, your partner, or anyone in your families ever had the following conditions?					
History of:	**Yes**	**No**	**History of:**	**Yes**	**No**
Anencephaly			Polycystic Kidney Disease		
Baby who died at birth or in first year			Sickle Cell Disease		
Blindness/ Deafness			Skeletal Disorder		
Cleft Lip/ Cleft Palate			Spina Bifida		
Cystic Fibrosis			Spinal Muscular Atrophy		
Down Syndrome			Tay Sachs/ Canavan Disease		
Heart Defect at Birth			Thalassemia		
Hemophilia			2 or more unexplained miscarriages		
Mental Retardation or Fragile X			Other Chromosome Problem		
Muscular Dystrophy			Any Birth defects not listed above		
Neurofibromatosis			Any Inherited genetic condition		