



Genetic History

Name: _____

Ethnic Group	Are any of your blood relatives:	Or your partner's relatives:
Caucasian, Hispanic, English, Irish	Yes _____ No _____	Yes _____ No _____
Mediterranean (Greek, Italian)	Yes _____ No _____	Yes _____ No _____
Asian	Yes _____ No _____	Yes _____ No _____
Ashkenazi Jewish	Yes _____ No _____	Yes _____ No _____
French Canadian	Yes _____ No _____	Yes _____ No _____
African descent	Yes _____ No _____	Yes _____ No _____

Ethnic Group	Disease risk based on your ancestry:	Screening Test
All Groups	Neural tube defects (Extra folate)	Maternal serum AFP, ultrasound (once pregnant)
Caucasian, Hispanic, English, Irish	Cystic Fibrosis	Specific DNA-based test
Mediterranean (Greek, Italian)	Thalassemia	Hemoglobin electrophoresis, CBC
Asian	Thalassemia	Hemoglobin electrophoresis, CBC
Ashkenazi Jewish	Tay-Sachs disease Canavan disease, Gaucher disease Cystic Fibrosis	Serum hexosaminidase A Specific DNA-based test Specific DNA-based test
French Canadian	Tay-Sachs disease	Serum hexosaminidase A
African descent	Sickle cell anemia, Thalassemia	Hemoglobin electrophoresis, CBC

*****Please fill out both pages, and return to the medical assistant.*****



Genetic Screening History

Name: _____

Does anyone have	In your family or your partner's family		If yes, please describe
Mental retardation-----	Yes _____	No _____	_____
Down's syndrome-----	Yes _____	No _____	_____
Spina bifida or anencephaly -----	Yes _____	No _____	_____
Hydrocephalus (water on the brain)-----	Yes _____	No _____	_____
Cystic fibrosis (CF) -----	Yes _____	No _____	_____
Sickle cell anemia -----	Yes _____	No _____	_____
Thalassemia-----	Yes _____	No _____	_____
Hemophilia or other bleeding disorder -----	Yes _____	No _____	_____
Tay -Sachs disease-----	Yes _____	No _____	_____
Canavan disease -----	Yes _____	No _____	_____
Cancer -----	Yes _____	No _____	_____
Emphysema -----	Yes _____	No _____	_____
Polycystic Kidney disease-----	Yes _____	No _____	_____
Phenylketonuria (PKU) -----	Yes _____	No _____	_____
Cleft Lip or Palate-----	Yes _____	No _____	_____
Heart defect at birth-----	Yes _____	No _____	_____
Muscular Dystrophy -----	Yes _____	No _____	_____
Early onset blindness -----	Yes _____	No _____	_____
Early onset deafness -----	Yes _____	No _____	_____
Dwarfism-----	Yes _____	No _____	_____
Two or more miscarriages -----	Yes _____	No _____	_____
Infant or childhood deaths -----	Yes _____	No _____	_____
Fragile X syndrome or Fragile X carrier -----	Yes _____	No _____	_____
Any other inherited or genetic conditions-----	Yes _____	No _____	_____
Any other birth defects (please specify type) _____			
Are you and your partner blood relatives (i.e. first cousins, etc.)? -----			
	Yes _____	No _____	_____

If you answered yes to any of the above questions, you may benefit from meeting with a genetic counselor to review your family history and pregnancy risks. Would you like to meet with a genetic counselor? Yes _____ No _____

Patient Signature Date