Stanford MEDICINE

GENETIC SCREENING QUESTIONNAIRE

Stanford Medicine - Women's Health - Redwood City

Medical Record Number:
Patient name

Label

The information on this sheet is confidential

Communications

Preferred language:	How would you rate your spoken English? ☐Native ☐Fluent ☐Basic ☐Very Little
If you have difficulty with English, do you want us to discuss your care with anybody on your behalf? ☐Yes ☐No If "Yes", please state name, ph number, and relationship to you:	
Name of partner or 2nd parent of the baby:	
How is your partner or 2nd parent of the baby involved? ☐I live with them ☐Very involved ☐Somewhat involved ☐Involved very little ☐Not involved at all	
Do you give permission to share information with your partner or 2nd parent of the baby? ☐Yes ☐No ☐Not sure	What is your partner or 2nd parent of the baby's phone number?
Do you have children living at home? ☐Yes ☐No	

If "Yes", please list the names and ages of the children.

Name				
Age				

Psycho-Social Information

Do you have a history of clinical depression or anxiety requiring treatment?	Y	N	Have you ever been sexually, physically, or emotionally abused?	Y	N
Has your current partner ever hit, kicked, pushed, or slapped you?	Y	N	Do you feel threatened at home? If "Yes", please explain	Y	N
Do you have any beliefs that restrict the use of blood products?	Y	N	Do you work? ☐Yes ☐No If "Yes", ☐Full time ☐Part time ☐From home		
If you work, what type of work do you do?			If you work, please list your employer.		
Do you go to school? ☐Yes ☐No If "Yes", *may select several* ☐Full time ☐Part time ☐Work from home ☐Work on site					

Pregnancy

Are you carrying twins or multiples?	Y	N
Is this pregnancy a result of IVF (in vitro fertilization)?	Y	N
If IVF pregnancy: What was the transfer date? _____ Was the egg from a donor? ☐Yes ☐No Did you have any genetic screening/testing for the embryo(s)? ☐Yes ☐No		
Additional IVF Comments:		
Have you ever been pregnant before? ☐ Yes ☐ No		

In previous pregnancies have you ever experienced any of the following:

☐	Ectopic Pregnancy	☐	PPH (postpartum hemorrhage)
☐	Gestational Diabetes	☐	Developed postpartum depression
☐	Elevated blood pressure during pregnancy	☐	Shoulder Dystocia (baby's shoulder gets stuck during birth)
☐	Delivered a baby before 37 weeks gestation		
☐	Cesarean Section	☐	Delivered a baby with a heart defect or other congenital problem
☐	Severe Lacerations (3rd or 4th degree)		
Add any additional comments or complications:		☐	No significant complications

Genetics/Ancestry

Do you have Ashkenazi Jewish ancestry? ☐Yes ☐No If "Yes", were tested for conditions like Tay-Sachs, Gaucher's, Canavan Disease, Familial Dysautonomia, etc? ☐Yes ☐No
Do you have African ancestry? ☐Yes ☐No If "Yes", have you been tested for Sickle Cell trait? ☐Yes ☐No

Stanford MEDICINE GENETIC SCREENING QUESTIONNAIRE

Stanford Medicine - Women's Health - Redwood City

Medical Record Number:
Patient name

Label

The information on this sheet is confidential

Do you have Mediterranean or Asian ancestry? ☐Yes ☐No	If "Yes", have you been tested for Thalassemia? ☐Yes ☐No
Have you or your partner had any carrier screening for autosomal recessive diseases or other types of genetic testing? ☐Yes ☐No	If "Yes", what testing have you had?

Do you or the father have personal or family history of any of the following:

	Congenital Heart Defect		Sickle Cell Disease or Trait
	Autism		Hemophilia or other blood disorders
	Cystic Fibrosis		Two or more miscarriages or stillbirths
	Muscular Dystrophy or other physical disabilities		Unexplained infant or childhood deaths
	Tay-Sachs, Canavan Disease, or Familial Dysautonomia		
	Neural Tube Defect (Meningomyelocele, Spina Bifida, Anencephaly)		
	Chromosome disorders (Down Syndrome, Mongolism, Trisomy 13 or 18, translocation)		
	Other inherited genetic disease, chromosomal disorder, birth defects, or cardiac defects		
	No significant history	Please add any additional genetic related comments:	

Medications/Exposure Since Last Menstrual Period

Since your last menstrual period have you:

	Taken supplements, vitamins, herbs, or over-the-counter-drugs
	Taken lithium, valium, or anticonvulsants
	Taken accutane, iodides to treat hyperthyroidism, anticoagulants, or anticancer drugs
	Taken illicit/recreational drugs, alcohol, or cigarettes/nicotine
	Been exposed to chemicals or other dangers at work or home (e.g. paints, polishes, pesticides, leads, cats, hot baths, douching, x-rays, lifting)
	None
Please add additional details about your answer(s) above:	

Infection Assessment

Have you had Chickenpox/Shingles before or been vaccinated?	☐ Yes	☐ No	if "Yes", when?
Have you received the Influenza vaccine this year?	☐ Yes	☐ No	If "Yes", when?
Have you received the Tdap vaccine before?	☐ Yes	☐ No	If "Yes", when?
Have you been exposed to TB (Tuberculosis)?	☐ Yes	☐ No	If "Yes", please explain.
Have you been exposed to a STI (Sexually Transmitted Infection)? (Hepatitis, HIV, Syphilis, Gonorrhea, Chlamydia) ☐ Yes ☐ No If "Yes", please explain.			
Have you or your partner ever had oral herpes (cold sores) or genital herpes outbreaks? ☐ Yes ☐ No If "Yes", please explain.			
Have you recently been around a child with a rash?	☐ Yes	☐ No	If "Yes", please describe.
Have you had a blood transfusion in the past?	☐ Yes	☐ No	
Did you, your partner, or anyone you live with travel during the last 6 months? ☐ Yes ☐ No If "Yes", please describe			
Do you, your partner, or anyone you live with have travel plans during this pregnancy? ☐ Yes ☐ No If "Yes", please describe			

Pap Test Information

Have you ever had an abnormal Pap test result? ☐Yes ☐No If "Yes", please explain.	
What is the date of your last Pap test?	
What was the results of your last Pap test? ☐Normal ☐Abnormal ☐Not sure	