PREGNANCY RISK ASSESSMENT

Genetic and Birth Defect Questionnaire

1.	Will you be under 15 or over 35 years old when your baby is due?	____ yes	____ no
2.	Do you or any of your family members or relatives have a history of mental retardation, mental illness, epilepsy or other nervous system disease?	____ yes	____ no
3.	Is there a history of birth defects in any of your family or relatives?	____ yes	____ no
4.	Have you, your family, or any relatives ever had:		
	Down's syndrome	____ yes	____ no
	Spina Bifida, meningomyelocele (open spine), or hydrocephalus (water head)?	____ yes	____ no
	Hemophilia or bleeding disorders?	____ yes	____ no
	Muscular dystrophy?	____ yes	____ no
	Cystic fibrosis?	____ yes	____ no
	Other inherited disorders?	____ yes	____ no
5.	Are you or the father of the baby African American, Mediterranean, Asian?	____ yes	____ no
	If yes, have you even been screened for sickle cell trait, thalassemia, etc. and found to be positive?	____ yes	____ no
6.	Are you Jewish? If yes, are you of Central or Eastern European background?	____ yes	____ no
7.	Do you have a history of infertility, abortion, stillborn, or any serious pregnancy complications?	____ yes	____ no
8.	Do you smoke? (tobacco or other)	____ yes	____ no
9.	Do you drink alcohol?	____ yes	____ no
10.	Do you take any medications or drugs?	____ yes	____ no
11.	Do you have <u>any</u> history of changing cat litter, presently or in the past?	____ yes	____ no
12.	Do you or the father of your baby have a history of herpes infection or any other sexually transmitted disease?	____ yes	____ no
13.	Do you have a history of diabetes or thyroid disease?	____ yes	____ no
14.	Have you ever had high blood pressure, heart disease, tuberculosis, kidney disease, cancer or any other serious disease not already mentioned?	____ yes	____ no
15.	Have you ever had chicken pox?	____ yes	____ no
16.	Do you have regular exposure to children either in the work place or home?	____ yes	____ no

NAME _____ DOB: _____ DATE:_____