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A Mount Sinai venture

MFM ASSOCIATES

CARNEGIE IMAGING
The Leading Edge in Women's Ultrasound

Pregnancy and Family History Questionnaire

Name: _____ **DOB:** _____ **Occupation:** _____

Preferred Contact Number: _____ **Referring Physician:** _____

Partner's Name: _____ **DOB:** _____ **Occupation:** _____

Please answer the following questions and provide an explanation when applicable. If you have any questions, then your genetic counselor will review the questionnaire with you.

Are you or your partner from any of these ethnic backgrounds? Please check all that apply.

☐ Caucasian ☐ African American ☐ Asian ☐ Hispanic
☐ Jewish ☐ African ☐ Asian Indian ☐ Central American
☐ Mediterranean *(Greek, Italian, etc.)* ☐ Caribbean ☐ Middle Eastern ☐ Cajun / French Canadian
☐ Other: _____

Have you, your partner, or anyone in your families ever had the following conditions:

	Yes	No		Yes	No
1. Down syndrome			8. Three or more pregnancy losses		
2. Other chromosome abnormality			9. Infant or childhood death		
3. Intellectual disability or autism			10. Stillborn		
4. Spina bifida (open spine)			11. Other inherited or genetic condition		
5. Heart defect at birth			12. Other serious medical condition or surgery		
6. Cleft lip/ Cleft palate			13. Any birth defect not listed above		
7. Blindness/ Deafness			14: Other:		

Please complete the following patient information pertaining to this current pregnancy.

	Yes	No
1. Are you taking any medications? Please List: _____		
2. Have you had exposure to alcohol, recreational drugs, cigarettes or X-rays?		
3. Was an egg/sperm/embryo donor used to achieve this pregnancy?		
4. Was IVF or IVF with ICSI used to achieve this pregnancy? Any PGS/PGD?		
5. Have you had prenatal screening or NIPT (e.g. Panorama/MaterniT21/"nuchal" screen)?		
6. Have you or your partner had carrier testing for any genetic conditions in this pregnancy or a previous pregnancy (e.g. Cystic Fibrosis, Tay-Sachs disease, etc.)?		

What is your Due Date? _____

Patient Signature: _____ Date: _____

Reviewed by: _____ Date: _____

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