

OB Questionnaire

The following questions will help in the care of your pregnancy. Your answers may indicate whether certain tests would be appropriate in helping to evaluate the health of your unborn baby. The following is a screening questionnaire only. If you have any further questions, ask your doctor.

Date: _____

Name: _____

Will you be age 35 or older when the baby is due?	Yes No	Your age:
Have you or the baby's father had a previous child, or a brother or sister with Down Syndrome?	Yes No	
Were you, the baby's father, any previous children, or any close relative born with a neural tube defect (such as spina bifida or anencephaly)?	Yes No	
Does any male relative in your family have: a. Hemophilia? b. Muscular dystrophy? c. Hydrocephalus (water on the brain)?	Yes No Yes No Yes No	
Do you or the baby's father have a birth defect, or have you had a child born dead or alive with a birth defect not listed in the above questions?	Yes No	
Does any close relative on either side of the family have cystic fibrosis?	Yes No	
Are there other known inherited or chromosomal disorder in the family?	Yes No	
Do you have one or more close family members who are mentally retarded?	Yes No	
Are you and the baby's father first cousins or more closely related?	Yes No	
Certain genetic diseases are more common in certain ethnic groups. a. Are you of Black ancestry? If yes, have you been tested for sickle cell trait? What were the results? b. Are you of Eastern European Jewish descent? If yes, have you been tested to see whether you are a Tay-Sachs carrier? What were the results? c. Are you of Asian or Mediterranean (Greek, Italian, etc.) descent? If yes, have you been tested for Thalassemia trait? What were the results?	Yes No Yes No Yes No Yes No Yes No Yes No	
Have you taken any medicines or drugs (prescription or not) during this pregnancy? If so, what kind?	Yes No	
Do you smoke and/or drink alcoholic beverages? Or, I don't drink at all when pregnant, and only an occasional glass of wine when not pregnant?	Yes No Yes No	
Do you, or have you in the past used marijuana or any other illegal drugs? If so, what?	Yes No	
Do you drink coffee, tea, or some other type of beverage containing caffeine on a daily basis? How much?	Yes No	