

Associated Women's Healthcare, LLP
Obstetrics, Gynecology & Infertility

OBSTETRIC QUESTIONNAIRE

Patient Name: _____

Date: _____

Circle appropriate answer

- | | | |
|---|-----|----|
| 1. Will you be age 35 or older when the baby is due? | YES | NO |
| 2. Have you, the baby's father, or anyone in either of your families ever had: | | |
| a. Down Syndrome (mongolism) or mental deficiency? | YES | NO |
| b. Defect of the brain or spinal cord? | YES | NO |
| c. Hemophilia (blood clotting disorder)? | YES | NO |
| d. Muscular dystrophy? | YES | NO |
| e. Inherited anemia (ex. Sickle Cell, Thalassemia), AIDS or other blood problems? | YES | NO |
| 3. Have you or the baby's father had a child with a birth defect not listed in question 2 above? | YES | NO |
| 4. Do you, the baby's father, or close relative in either family have any inherited genetic or chromosomal disorder not listed above? | YES | NO |
| 5. Have you had three or more spontaneous pregnancy losses? | YES | NO |
| 6. Do you or the baby's father have any close relatives descendent from Jewish people who live in Eastern Europe (Ashkenazic Jew)? | YES | NO |

If yes, have either you (YES / NO) or the baby's father been screened for Tay-Sachs, Canavan Disease, Niemann- Pick, Fanconi anemia, Bloom syndrome, Gaucher Disease or Familial Dysautonomia?

Results: You _____ Father _____

YES NO

- | | | |
|---|-----|----|
| 7. Do you have a family history of cystic fibrosis? | YES | NO |
|---|-----|----|

If not, the risk of being a carrier of cystic fibrosis may be as high as 1/29 in some ethnic groups. The risk of a carrier state by ethnicity is as follows:

Northern European Caucasians	1/29
Ashkenazi Jewish People	1/29
Hispanic Americans	1/46
African Americans	1/60
Asian Americans	1/90

I would like to have screen for cystic fibrosis:	YES	NO
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- | | | |
|--|-----|----|
| 8. Do you have any religious objections to any form of medical treatment (ex. Refusal of blood transfusion)? | YES | NO |
|--|-----|----|

If yes, please describe: _____

Patient's Signature

Date

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