

Preconception/prenatal family history questionnaire

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Today's date: _____
 Person completing questionnaire: _____

	Patient	Partner/spouse
Name		
Date of birth		
Occupation		
Marital status (married, divorced, widowed, single)		
Last grade completed		
Height		
Weight		
Adopted	<input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> Yes <input type="radio"/> No

Past medical history *Check all that apply*

	You	Partner	Explain checked items, include year or age
Surgeries	<input type="checkbox"/>	<input type="checkbox"/>	_____
Hospitalizations	<input type="checkbox"/>	<input type="checkbox"/>	_____
Major illnesses	<input type="checkbox"/>	<input type="checkbox"/>	_____
Chronic medical problems	<input type="checkbox"/>	<input type="checkbox"/>	_____
Allergies	<input type="checkbox"/>	<input type="checkbox"/>	_____
Learning problems	<input type="checkbox"/>	<input type="checkbox"/>	_____
Behavior problems	<input type="checkbox"/>	<input type="checkbox"/>	_____
Mental illness	<input type="checkbox"/>	<input type="checkbox"/>	_____

Ethnic Background

Where did your and your partner's ancestors come from before the United States? *Check all that apply*

	You	Partner
Mediterranean (e.g., Italian, Greek)	<input type="checkbox"/>	<input type="checkbox"/>
European Caucasian (e.g., Irish, English, German)	<input type="checkbox"/>	<input type="checkbox"/>
African or African-American	<input type="checkbox"/>	<input type="checkbox"/>
Ashkenazi Jewish	<input type="checkbox"/>	<input type="checkbox"/>
Hispanic (e.g., Puerto Rican, Dominican, Mexican)	<input type="checkbox"/>	<input type="checkbox"/>
Cajun or French Canadian	<input type="checkbox"/>	<input type="checkbox"/>
Southeast Asian (e.g., Laotian, Chinese, Vietnamese)	<input type="checkbox"/>	<input type="checkbox"/>
Indian (from India)	<input type="checkbox"/>	<input type="checkbox"/>
Middle Eastern (e.g., Lebanese, Iranian, Egyptian)	<input type="checkbox"/>	<input type="checkbox"/>
Native American	<input type="checkbox"/>	<input type="checkbox"/>
Other _____	<input type="checkbox"/>	<input type="checkbox"/>

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Date of first day of last menstrual period _____
Your age ____ If pregnant: your age at delivery _____
Current age of partner _____

Do you:

(if pregnant, also include all exposures since last menstrual period)

	Yes	No
Take any medications (prescription or non-prescription)?	<input type="radio"/>	<input type="radio"/>
Take a daily multivitamin or folic acid supplement?	<input type="radio"/>	<input type="radio"/>
Drink alcohol (beer, wine, hard liquor)?	<input type="radio"/>	<input type="radio"/>
Smoke cigarettes?	<input type="radio"/>	<input type="radio"/>
Use any recreational drugs (cocaine, marijuana, heroin)?	<input type="radio"/>	<input type="radio"/>

For any "yes" answers, describe below, including amounts and dates, if known.

Have you had:

	Yes	No	Have you been exposed to:	Yes	No
Chicken pox (varicella)	<input type="radio"/>	<input type="radio"/>	Radiation (x-rays)	<input type="radio"/>	<input type="radio"/>
Fifth disease (parvovirus)	<input type="radio"/>	<input type="radio"/>	Chemicals (e.g., organic solvents, mercury)	<input type="radio"/>	<input type="radio"/>
Cytomegalovirus	<input type="radio"/>	<input type="radio"/>	Raw meat (e.g., eaten steak tartar)	<input type="radio"/>	<input type="radio"/>
Toxoplasmosis	<input type="radio"/>	<input type="radio"/>			

For any "yes" answers, describe below, including dates and details, if known.

Did your mother take a medication called "DES" while pregnant with you? Yes no I don't know

Do you have a personal history of:

	Yes	No
Thyroid disease	<input type="radio"/>	<input type="radio"/>
Diabetes	<input type="radio"/>	<input type="radio"/>
Seizures	<input type="radio"/>	<input type="radio"/>
Hyperphe or phenylketonuria (PKU)	<input type="radio"/>	<input type="radio"/>
Deep vein thrombosis	<input type="radio"/>	<input type="radio"/>
Lupus	<input type="radio"/>	<input type="radio"/>
Other chronic conditions:	<input type="radio"/>	<input type="radio"/>

Please list total number of prior:

Pregnancies	_____
Full-term births	_____
Preterm births (<37 wks)	_____
Stillbirths	_____
Miscarriages (<24 wks)	_____
Elective abortions	_____
Living children	_____

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For the questions below, please check the boxes for those conditions that have occurred in your or your partners'/spouse's families. Include yourself AND your spouse/partner, as well as your and his siblings (full and half), parents, children, grandparents, aunts, uncles, nieces, nephews and first cousins, if possible.

	Your Family	Partner's Family	Who is affected? (you, parent, sib, etc.)
Anencephaly or spina bifida (openings in the skull or spine)	<input type="checkbox"/>	<input type="checkbox"/>	_____
Hydrocephalus (water on the brain)	<input type="checkbox"/>	<input type="checkbox"/>	_____
A large, small or unusually shaped head	<input type="checkbox"/>	<input type="checkbox"/>	_____
Blindness or other vision problems	<input type="checkbox"/>	<input type="checkbox"/>	_____
Cataracts	<input type="checkbox"/>	<input type="checkbox"/>	_____
Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>	_____
Deafness or significant hearing loss	<input type="checkbox"/>	<input type="checkbox"/>	_____
Unusual shape, size or position of ears	<input type="checkbox"/>	<input type="checkbox"/>	_____
Cleft lip and/or cleft palate (opening in lip and/or roof of the mouth)	<input type="checkbox"/>	<input type="checkbox"/>	_____
Dental problems (missing, extra or abnormally formed teeth)	<input type="checkbox"/>	<input type="checkbox"/>	_____
Speech problems	<input type="checkbox"/>	<input type="checkbox"/>	_____
Congenital heart defect (e.g., "hole" in the heart)	<input type="checkbox"/>	<input type="checkbox"/>	_____
Heart attack or coronary artery disease	<input type="checkbox"/>	<input type="checkbox"/>	_____
Respiratory disease or chronic lung condition	<input type="checkbox"/>	<input type="checkbox"/>	_____
Asthma	<input type="checkbox"/>	<input type="checkbox"/>	_____
Allergies	<input type="checkbox"/>	<input type="checkbox"/>	_____
Cystic fibrosis	<input type="checkbox"/>	<input type="checkbox"/>	_____
Alpha-1-antitrypsin deficiency	<input type="checkbox"/>	<input type="checkbox"/>	_____
Pyloric stenosis	<input type="checkbox"/>	<input type="checkbox"/>	_____
Birth defects of the bowels or intestines	<input type="checkbox"/>	<input type="checkbox"/>	_____
Kidney problems	<input type="checkbox"/>	<input type="checkbox"/>	_____
Polycystic kidneys, missing or extra kidneys	<input type="checkbox"/>	<input type="checkbox"/>	_____
Genital or urinary tract defects	<input type="checkbox"/>	<input type="checkbox"/>	_____
Congenital hip dislocation (born with dislocated hips)	<input type="checkbox"/>	<input type="checkbox"/>	_____
A birth defect of an arm or a leg	<input type="checkbox"/>	<input type="checkbox"/>	_____
Unusually formed bones or many broken bones	<input type="checkbox"/>	<input type="checkbox"/>	_____
Scoliosis (curved spine)	<input type="checkbox"/>	<input type="checkbox"/>	_____

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	Your Family	Partner's Family	Who is affected? (you, parent, sib, etc.)
Unusually formed hands or feet (including club foot)	<input type="checkbox"/>	<input type="checkbox"/>	_____
Very short or tall stature	<input type="checkbox"/>	<input type="checkbox"/>	_____
Dwarfism	<input type="checkbox"/>	<input type="checkbox"/>	_____
Marfan syndrome	<input type="checkbox"/>	<input type="checkbox"/>	_____
Muscle weakness or poor coordination	<input type="checkbox"/>	<input type="checkbox"/>	_____
Muscular dystrophy	<input type="checkbox"/>	<input type="checkbox"/>	_____
Mental retardation or developmental delay	<input type="checkbox"/>	<input type="checkbox"/>	_____
Learning disabilities or a slow learner	<input type="checkbox"/>	<input type="checkbox"/>	_____
Attention deficit or hyperactivity	<input type="checkbox"/>	<input type="checkbox"/>	_____
Autism	<input type="checkbox"/>	<input type="checkbox"/>	_____
Seizures, epilepsy or convulsions	<input type="checkbox"/>	<input type="checkbox"/>	_____
Down syndrome or other chromosome syndrome	<input type="checkbox"/>	<input type="checkbox"/>	_____
Fragile X syndrome	<input type="checkbox"/>	<input type="checkbox"/>	_____
Tay-Sachs disease	<input type="checkbox"/>	<input type="checkbox"/>	_____
Canavan disease	<input type="checkbox"/>	<input type="checkbox"/>	_____
Phenylketonuria (PKU)	<input type="checkbox"/>	<input type="checkbox"/>	_____
Gaucher disease	<input type="checkbox"/>	<input type="checkbox"/>	_____
Alzheimer disease or other form of dementia	<input type="checkbox"/>	<input type="checkbox"/>	_____
Huntington disease	<input type="checkbox"/>	<input type="checkbox"/>	_____
Neurofibromatosis	<input type="checkbox"/>	<input type="checkbox"/>	_____
Schizophrenia or other mental illness	<input type="checkbox"/>	<input type="checkbox"/>	_____
Manic depression (bipolar)	<input type="checkbox"/>	<input type="checkbox"/>	_____
Unipolar disorder (severe depression)	<input type="checkbox"/>	<input type="checkbox"/>	_____
Birthmarks or unusual growths on skin	<input type="checkbox"/>	<input type="checkbox"/>	_____
A chronic skin condition (e.g., eczema)	<input type="checkbox"/>	<input type="checkbox"/>	_____
Patches of different colored hair	<input type="checkbox"/>	<input type="checkbox"/>	_____
Patches of different colored skin	<input type="checkbox"/>	<input type="checkbox"/>	_____
Bleeding or clotting disorder (e.g., Hemophilia)	<input type="checkbox"/>	<input type="checkbox"/>	_____
Hereditary anemia (e.g., thalassemia, sickle cell, other)	<input type="checkbox"/>	<input type="checkbox"/>	_____

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	Your Family	Partner's Family	Who is affected? (you, parent, sib, etc.)
Deep vein thrombosis	<input type="checkbox"/>	<input type="checkbox"/>	_____
Factor V Leiden	<input type="checkbox"/>	<input type="checkbox"/>	_____
High cholesterol	<input type="checkbox"/>	<input type="checkbox"/>	_____
Stroke	<input type="checkbox"/>	<input type="checkbox"/>	_____
Hemochromatosis (iron storage condition)	<input type="checkbox"/>	<input type="checkbox"/>	_____
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	_____
Thyroid disease	<input type="checkbox"/>	<input type="checkbox"/>	_____
High blood pressure or hypertension	<input type="checkbox"/>	<input type="checkbox"/>	_____
Breast cancer	<input type="checkbox"/>	<input type="checkbox"/>	_____
Ovarian cancer	<input type="checkbox"/>	<input type="checkbox"/>	_____
Colon cancer	<input type="checkbox"/>	<input type="checkbox"/>	_____
Other cancers or tumors	<input type="checkbox"/>	<input type="checkbox"/>	_____
Stillbirths	<input type="checkbox"/>	<input type="checkbox"/>	_____
Infant or childhood deaths	<input type="checkbox"/>	<input type="checkbox"/>	_____
Two or more miscarriages or pregnancy losses (in the same person)	<input type="checkbox"/>	<input type="checkbox"/>	_____
Infertility or sterility (unable to get pregnant or have children)	<input type="checkbox"/>	<input type="checkbox"/>	_____
Premature ovarian failure (early menopause)	<input type="checkbox"/>	<input type="checkbox"/>	_____
Primary amenorrhea (never had a period)	<input type="checkbox"/>	<input type="checkbox"/>	_____

Have you, your partner/spouse, or anyone in your family had genetic testing? Yes No
 If yes, please explain:

Are you and your partner/spouse related as first cousins or in any other way as blood relatives? Yes No
 If yes, please explain:

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Significant findings

Recommendations

Date discussed with patient/family _____

HCP name/initials _____

Patient/parent/guardian signature

X
