Preconception/prenatal family history questionnaire

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	○ Yes ○ No	○ Yes ○ No

Past medical history *Check all that apply*

	You	Partner	Explain checked items, include year or age
Surgeries	☐	☐	
Hospitalizations	☐	☐	
Major illnesses	☐	☐	
Chronic medical problems	☐	☐	
Allergies	☐	☐	
Learning problems	☐	☐	
Behavior problems	☐	☐	
Mental illness	☐	☐	

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)	☐	☐
European Caucasian (e.g., Irish, English, German)	☐	☐
African or African-American	☐	☐
Ashkenazi Jewish	☐	☐
Hispanic (e.g., Puerto Rican, Dominican, Mexican)	☐	☐
Cajun or French Canadian	☐	☐
Southeast Asian (e.g., Laotian, Chinese, Vietnamese)	☐	☐
Indian (from India)	☐	☐
Middle Eastern (e.g., Lebanese, Iranian, Egyptian)	☐	☐
Native American	☐	☐
Other_____	☐	☐

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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)?	○	○
Take a daily multivitamin or folic acid supplement?	○	○
Drink alcohol (beer, wine, hard liquor)?	○	○
Smoke cigarettes?	○	○
Use any recreational drugs (cocaine, marijuana, heroin)?	○	○

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)	○	○	Radiation (x-rays)	○	○
Fifth disease (parvovirus)	○	○	Chemicals *(e.g., organic solvents, mercury)*	○	○
Cytomegalovirus	○	○			
Toxoplasmosis	○	○	Raw meat *(e.g., eaten steak tartar)*	○	○

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	○	○
Diabetes	○	○
Seizures	○	○
Hyperphe or phenylketonuria (PKU)	○	○
Deep vein thrombosis	○	○
Lupus	○	○
Other chronic conditions:	○	○

_____

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

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

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

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 _____

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