OB/GYN SPECIALISTS OF COLUMBUS, P.C.

RUTHANN F. REES, M.D., PH.D.

PRENATAL/GENETIC SCREENING QUESTIONNAIRE

These questions apply to members of your family AND those of the baby's father's family. If you do not understand any of these questions, please mark the ones in question so that we may discuss them during your consultation.

1. How old will you be when your baby is born? _____

Please circle ***YES*** or ***NO*** in answer to the questions that follow:

2. Have you had 3 or more stillborn births or miscarriages? ***YES*** ***NO***

3. Do you, the baby's father, or anyone in either family have a history of:

- Thalassemia (Italian, Greek, Mediterranean or South Asian background ***YES*** ***NO***
- Down's Syndrome (Mongolism) ***YES*** ***NO***
- Bleeding problem (Hemophilia) ***YES*** ***NO***
- Cystic fibrosis ***YES*** ***NO***
- Huntington chorea ***YES*** ***NO***
- Mental retardation ***YES*** ***NO***
- Tay-Sachs (Jewish background) ***YES*** ***NO***

4. Muscular problem (Muscular dystrophy, Duchenne's muscular dystrophy) ***YES*** ***NO***

5. Sickle cell trait or disease. If you, or the baby's father are black, have both been screened for sickle cell disease? If yes, give results _____ ***YES*** ***NO***

6. Neural tube defects such as spinal bifida or open spine, anecephaly or lack of brain development, or meningomyelocele. ***YES*** ***NO***

7. Hydrocephalus (Water head) ***YES*** ***NO***

8. Any genetic, chromosomal, or inherited problem? ***YES*** ***NO***

   Have you or the baby's father had a child with birth defects not listed above? ***YES*** ***NO***

9. Are you concerned about any other problem your baby might have? ***YES*** ***NO***

_____ _____ _____

Patient's Name Patient's Signature Date

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