

Date of Appointment _____

Section 1. Patient Information

Name _____ Date of Birth _____ Occupation _____
Address _____ City _____ State _____ Zip _____
Home phone _____ Work phone _____ Cell phone _____
Referring Physician's Name _____ Referring Physician's Phone Number _____

Section 2. Partner Information (If patient is pregnant, then "partner" is the father of the pregnancy)

Name _____ Date of Birth _____ Occupation _____

The following questions will help your genetic counselor complete a genetic risk assessment and determine if certain tests are appropriate. If you are unsure about your family history, please speak with family members.

Section 3. Are you or your partner from any of these ethnic backgrounds?

Please circle and check all that apply

Chinese, Taiwanese, Asian Indian, Pakistani, Filipino, Pacific Islander or Southeast Asian
Italian, Greek, Middle Eastern, Spanish or Portuguese
Jewish, French Canadian or Cajun
African American, African descent, Black, Puerto Rican, Caribbean or Central American.
Hispanic or Mexican
Japanese or Korean.
Caucasian
Other (specify) _____

Section 4. Have you, your partner or anyone in your families ever had the following conditions:

Down syndrome
other chromosome problem
mental retardation, autism, developmental delay.
spina bifida (open spine).
anencephaly (open head/brain).
cystic fibrosis (a lung disease)
muscular dystrophy or neuromuscular disease
skeletal disorder, like dwarfism
neurofibromatosis
polycystic kidney disease
Huntington disease
heart defect at birth
cleft lip/cleft palate
blindness / deafness.
blood disorder, such as hemophilia or sickle cell
stroke or blood clot at age less than 50.
any other birth defect/genetic/inherited condition
any other serious medical condition or surgery

Section 5. Please complete the following patient information:

Are you currently pregnant?
If yes, what is your due date?
If yes, was this pregnancy achieved with IVF?
In this pregnancy, have you used or are you considering:
donor egg (age of donor) or donor sperm?
preimplantation genetic diagnosis/screening (PGD/PGS)
intracytoplasmic sperm injection (ICSI)
Do you have diabetes, PKU or lupus?
Have you had any of the following: maternal serum screening, AFP blood test, triple marker screen, quad screen, first trimester screen, sequential screen, integrated screen?
I have answered these questions to the best of my knowledge.

Patient's signature Date

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Reviewed by: _____ Date: _____