COASTAL FERTILITY Medical Center | RSMC Irvine

Medical Director: Lawrence B. Werlin M.D.

Family History Questionnaire

Genetic Family History & Pregnancy Questionnaire

Date of Appointment _____

Section 1. Patient Information

Patient's 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 Patien is pregnant, "partner" means the father of the pregnancy)

Partner's name _____

Date of Birth _____

Occupation _____

The following questions may help your doctor or genetic counselor complete a genetic risk assessment and determine if certain genetic 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?

Ethnic Background	Patient	Partner
Chinese, Taiwanese, Asian Indian, Pakistani, Filipino 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		
Caucasian		
Other (specify)		

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

Condition	Yes	No
Down Syndrome		
Other Chromosome problems		
Mental retardation, autism, or developmental delay		
Spina bifida (open spine)		
Anencephaly (opening in head/brain		
Blood disorder, such as hemophilia or sickle cell		
Muscular dystrophy or neuromuscular disease		
Cystic fibrosis		
Neurofibromatosis		
Skeletal disorder, like dwarfism		
Polycystic kidney disease		
Huntington disease or other adult neurological diseases (e.g. dementia, Alzheimer's		
Heart defect		
Cleft lip/cleft palate		
Blindness/deafness		
Baby who died at birth or within first year		
Stillborn or 2 or more pregnancy losses		
Any birth defect not in this list		
Any other inherited (genetic) condition.		
Any other serious medical condition or surgery		
Are you or your partner adopted?		
Are you and your partner related to each other (other than by marriage)?		
Is there a history of infertility in either you and /or your partner?		
Please specify the cause of infertility, if known		
Have you and / or your partner had:		
Carrier testing for cystic fibrosis?		
Carrier testing for any other genetic disorder?		
Blood chromosome testing?		

Section 5. Please complete the following patient information:

	Yes	No
Current medications If yes please list:	☐	☐
Recreational Drugs	☐	☐
Alcoholic drinks	☐	☐
Cigarette smoking	☐	☐
Do you have diabetes, PKU (phenylketonuria) or lupus?	☐	☐
Are you considering or have you used:	☐	☐
Egg donor or donor sperm?	☐	☐
Preimplantation genetic diagnosis (PGD) or preimplantation genetic screening (PGS)?	☐	☐
Intracytoplasmic sperm injection (ICSI)?	☐	☐

Section 6. If you are currently pregnant:

What is your due date?:	☐	☐
Have you had any of the following:	☐	☐
Rashes, infections, fevers?	☐	☐
Spotting, bleeding or any other complications?	☐	☐
Exposure to X-rays?	☐	☐
Maternal serum screening (AFP blood screen, AFP3, Afp4, triple marker screen, first trimester screen)?	☐	☐

I have answered these questions to the best of my knowledge.

_____

Patient's signature **Date**