
GENETIC SCREENING/TERATOLOGY COUNSELING

Includes patient, baby's father, or anyone in either family

Name: _____

D.O.B.: ____/____/____

	YES	NO
1. Patient's age is greater than 35 years	_____	_____
2. Thalassemia (Italian, Greek Mediterranean or Asian background)	_____	_____
3. Neural Tube Defect (Meningomyelocele, Spina Bifida or Anencephaly)	_____	_____
4. Congenital Heart Defect	_____	_____
5. Down Syndrome	_____	_____
6. Tay-Sachs (e.g. Jewish, Cajun or French Canadian background)	_____	_____
7. Sickle Cell Disease or Trait (African)	_____	_____
8. Hemophilia	_____	_____
9. Muscular Dystrophy	_____	_____
10. Cystic Fibrosis	_____	_____
11. Huntington Chorea	_____	_____
12. Mental Retardation/Autism (If yes, was the person tested for Fragile X?)	_____	_____
13. Other Inherited Genetic or Chromosomal Disorder	_____	_____
14. Maternal Metabolic Disorder (e.g. Insulin Dependent Diabetes, PKU)	_____	_____
15. Patient or baby's father had a child with Birth Defects not listed above	_____	_____
16. Recurrent Pregnancy loss or a Stillbirth	_____	_____
17. Medications, Street Drugs, Alcohol since last Menstrual Period	_____	_____
If yes, please list _____		
18. Other Comments _____		