Stanford MEDICINE
Children's Health
STANFORD UNIVERSITY MEDICAL CENTER ● 725 Welch Road, Palo Alto, CA 94304

OB Genetics Outpatient Record ● OB Genetics Screening Questionnaire

Medical Record Number

Patient Name

Patient name: _____
Pronouns: ☐ She/her ☐ He/him ☐ They/them ☐ Other
Date of birth: _____ Occupation: _____

Partner's name: _____
Pronouns: ☐ She/her ☐ He/him ☐ They/them ☐ Other
Date of birth: _____ Occupation: _____

Family and Patient Histories

1. Is your family or the father of the pregnancy's family:
   a. Southeast Asian, Taiwanese, Chinese, or Filipino? ☐ No ☐ Yes
   b. Italian, Greek, Middle Eastern, or Indian Subcontinent? ☐ No ☐ Yes
   c. African or African-American (Black)? ☐ No ☐ Yes
   d. Jewish? ☐ No ☐ Yes
   e. Cajun or French Canadian? ☐ No ☐ Yes
   f. Caucasian? If yes, what country?_____ ☐ No ☐ Yes
   g. Hispanic? If yes, what country?_____ ☐ No ☐ Yes
2. Are you and the father of the pregnancy related by blood (such as cousins)? ☐ No ☐ Yes
3. Have you, the father of the pregnancy, or anyone in either of your families ever had any of the following?
   a. Chromosomal abnormalities (such as Down syndrome) ☐ No ☐ Yes
   b. Neural tube defect (spina bifida, anencephaly) ☐ No ☐ Yes
   c. Blood disorder (such as hemophilia, sickle cell, thalassemia, clotting disorder) ☐ No ☐ Yes
   d. Nerve or muscle disorder (such as neurofibromatosis, muscular dystrophy) ☐ No ☐ Yes
   e. Bone or skeletal disorder (such as dwarfism) ☐ No ☐ Yes
   f. Cystic fibrosis (a lung disease) ☐ No ☐ Yes
   g. Kidney abnormalities ☐ No ☐ Yes
   h. Heart defect (at birth) ☐ No ☐ Yes
   i. Cleft lip/palate ☐ No ☐ Yes
   j. Intellectual disability/Autism/Developmental delay ☐ No ☐ Yes
   k. A baby who died shortly after birth or in childhood? ☐ No ☐ Yes
   l. A stillbirth or two or more miscarriages? ☐ No ☐ Yes
   m. Needed surgery before one year of age? ☐ No ☐ Yes
   n. Cancer in childhood or young adulthood? ☐ No ☐ Yes
   o. Blindness or deafness not related to age? ☐ No ☐ Yes
   p. Any genetic condition not listed above: _____ ☐ No ☐ Yes
   q. Any birth defect not listed above: _____ ☐ No ☐ Yes
   r. A medical problem that you are concerned about? _____ ☐ No ☐ Yes

4. Have you or the father of the pregnancy had any genetic tests (such as cystic fibrosis, Tay-Sachs, Canavan or sickle cell screening)? If yes, please specify: _____ ☐ No ☐ Yes

Current pregnancy history (if applicable)

5. Was this pregnancy started through in-vitro fertilization (IVF) or other reproductive technology? ☐ No ☐ Yes
   If yes, please specify: ☐ sperm donor ☐ egg donor (donor age) _____ ☐ ICSI ☐ Other: _____
6. Have you used medications (excluding vitamins), tobacco, alcohol or recreational drugs? ☐ No ☐ Yes
7. Do you have diabetes (gestational, type 1 or type2)? ☐ No ☐ Yes
8. Have you had the California Prenatal Screening Program blood test? If yes, when? _____ ☐ No ☐ Yes
9. Have you had cell-free DNA screening (NIPT, NIPS)? If yes, when? _____ ☐ No ☐ Yes
10. If yes to any question above, explain:_____

_____ _____
SIGNATURE (Patient, Parent, or Properly designated representative) DATE

DATE: TIME:	Genetic counselor signature
	PRINT name: