Name: LAST\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ FIRST\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_\_

1. What is your ethnicity? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ What is the ethnicity of the baby’s father? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**CIRCLE YES OR NO**

1. YES or NO Have you or has the baby’s father had a child born with a birth defect?
2. YES or NO Did either you or the baby’s father have a birth defect?
3. Please describe any special needs that have occurred in the children of your family (eg, cognitive impairment/intellectual disability, birth defects, deformities, or inherited diseases, such as hemophilia, muscular dystrophy, or cystic fibrosis):

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. YES or NO Do you or does the baby’s father have a history of pregnancy losses (miscarriages or stillbirths)?
2. YES or NO Some genetic problems occur in couples with certain racial or ancestral backgrounds. Please check if you are, or the baby’s father is, on of these back grounds.

YES or NO Eastern European Jewish (Ashkenazi) Ancestry

If yes, have you had tay-sachs screening tests?

If yes, have you had canavan screening tests?

If yes, have you had familial dysautonmia screening?

Date: \_\_\_\_/\_\_\_\_/\_\_\_\_ Result:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

YES or NO African American

If yes, have you had Sickle Cell screening?

Date:\_\_\_\_/\_\_\_\_/\_\_\_\_ Result:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

YES or NO Mediterranean Ancestry or Southeast Asian Ancestry

If yes, have you had screening for inherited forms of anemia such as Thalassemia?

YES or NO French Canadian or Cajun Ancestry

If yes, have you had tay-sachs screening tests?

1. YES or NO Have you had cystic fibrosis screening?
2. YES or NO Have you had any other genetic carrier screening, such as expanded carrier screening?

Screening \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_\_/\_\_\_\_/\_\_\_\_ Result:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. Please list any other concerns you have about birth defects or inherited disorders:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. YES or NO Do you want a test that will tell you about your risk to have a baby with Down Syndrome?
2. YES or NO Is the father 45 years or older?