Laura Musser DO, LLC
Julie Brennan WHNP-BC
22 McClurg Road • Boardman, OH 44512
Phone: (330) 550-9431 • Fax (330) 330-8158

PRENATAL GENETICS SCREEN

Name ______________________________ Date ______________________

Date of Last Menstrual Period ______________________________

(Please check the Yes or No box below)

1. Will you be 35 years or older when the baby is due?.................... ❑Yes ❑No

2. Have you, the baby's father, or anyone in either of your families ever had any of the following disorders? (If yes, please indicate relationship to you) Relationship:
   - Downs Syndrome (mongolism).. ❑Yes ❑No ________
   - Chromosomal Abnormality.. ❑Yes ❑No ________
   - Neural tube defect (spina bifida, anencephaly)................ ❑Yes ❑No ________
   - Hemophilia.. ❑Yes ❑No ________
   - Muscular Dystrophy.. ❑Yes ❑No ________
   - Cystic Fibrosis.. ❑Yes ❑No ________
   - Huntington's Chorea.. ❑Yes ❑No ________

3. Did you or the baby's father have a birth defect?......................... ❑Yes ❑No
   If yes, who has the defect and what is it?
   ____

4. In any previous pregnancies, have you or the baby's father had a child, born dead or alive, with a birth defect not listed in question 3?................................ ❑Yes ❑No

5. Do you or the baby's father have any close relatives with developmental disabilities?....... ❑Yes ❑No

6. Do you, the baby's father, or a close relative in either of your families, have a birth defect, familial disorder, or a chromosomal abnormality not listed above?......................... ❑Yes ❑No

7. In any previous pregnancies, have you or the baby's father had a stillborn child, or three or more first trimester miscarriages?................................ ❑Yes ❑No

8. Are you or the baby's father of Jewish ancestry? .... ❑Yes ❑No
   If yes, have either of you been tested for Tay-Sachs disease?................................ ❑Yes ❑No

9. Are you or the baby's father African-American?................................ ❑Yes ❑No
   If yes, have either of you been tested for sickle cell trait? .... ❑Yes ❑No

10. Are you or the baby's father of Italian, Greek, or Mediterranean background? .... ❑Yes ❑No
    If yes, have either of you been tested for B-thalassemia?................................ ❑Yes ❑No

11. Are you or the baby's father Philippine or Southwest Asian ancestry?................................ ❑Yes ❑No
    If yes, have either of you been tested for a-thalassemia?................................ ❑Yes ❑No

12. Excluding iron and vitamins, have you taken any medications or recreational drugs since being pregnant or since your last menstrual period? .... ❑Yes ❑No
    If yes, give the name of the mediation and the time taken during pregnancy:
    ____

Race: ❑ White / Caucasian ❑ Hispanic ❑ American Indian
❑ Black / African American ❑ Asian ❑ Other ______________

______________________________ ______________________________
Patient's Signature Patient's Name (Printed/Typed)

Laura Musser DO, LLC
Julie Brennan WHNP-BC
22 McClurg Road • Boardman, OH 44512
Phone: (330) 550-9431 • Fax (330) 330-8158

HEALTH HISTORY

Please check box with a plus sign (+) if personal history or family history of diseases listed below. If answer is no, check each box with a minus sign (-). If yes, please explain, family member and type of problem.

	Personal History	Family History	If (+) Explain
Heart Disease			
Lung Disease			
Stomach / Bowel Problems			
Hormone Problems / Diabetes			
Anemia / Bleeding Problems			
Neurological Problems			
Psychiatric Problems (Depression, Anxiety, etc.)			
Cancer			
Stillbirth or Birth Defect			
Genetic Problems			
Multiple Births			
Drug Addiction / Smoking / Alcohol			
Have you ever had Chicken Pox?			
Sexually Transmitted Disease / HIV			
Drug Allergies / Other Sensitivities			
Surgery			
Hospitalization			
Blood Transfusion			
Abnormal Paps / Cervical Surgeries			

OBSTETRICAL HISTORY

Please list ALL pregnancies including miscarriages and abortions.

Year	Length of Gestation	Length of Labor	Vag. or Ces. Delivery	Weight	Sex	Complications