

THE MUASHER CENTER FOR FERTILITY AND IVF

GENETIC SCREENING & PRECONCEPTION QUESTIONNAIRE

Name: _____ Date of Birth: _____

Partner's Name: _____ Date of Birth: _____

The following questionnaire will help us evaluate the need for individualized testing of you and your partner. Your answers will help us know what tests are appropriate. It is important to know if you or your partner are carriers for certain genetic diseases, which can be passed on. Please answer all questions as completely as possible. All information will be kept confidential.

Have you had a child born with birth defects? Yes No (circle one)

If yes, state which delivery and describe the defect:

Have either of you or a family member ever seen a genetic counselor or medical geneticist before?

Yes No

If yes, where and for what reason?

Are the two of you related by blood? Yes No

Are either you or your partner from any of these ethnic backgrounds?

Italian, Greek, Middle Eastern, Spanish, Southern Chinese, Asian Indian, Taiwanese, Filipino, or Southeast Asian

Yes No

Were you or your partner tested for Thalassemia or other hemoglobin abnormalities? If yes, who was tested and what were the results?

Are either you or your partner of Jewish background?

Yes No

Were you or your partner tested for Tay-sachs, cystic fibrosis, Canavan disease or Familial Dysautonomia? If yes, who was tested and what were the results?

Are either of you, African-American or of African descent?

Yes No

Were you or your partner tested for sickle cell trait? If yes, who was tested and what were the results?

THE MUASHER CENTER FOR FERTILITY AND IVF

Do you, your partner or anyone in your families have cystic fibrosis?

Yes No

Were you or your partner tested for cystic fibrosis? If yes, who was tested and what were the results?

Have you or your partner or any family member ever had any of the following:

	Female's Family		Male's Family	
1. A pregnancy/child with Down's syndrome?	Yes	No	Yes	No
2. A child with Mental retardation, Autism or Developmental delays?	Yes	No	Yes	No
3. A stillborn baby?	Yes	No	Yes	No
4. Cleft lip and or palate?	Yes	No	Yes	No
5. Heart defect at birth?	Yes	No	Yes	No
6. Spina bifida (open spine), skull defect, or anencephaly?	Yes	No	Yes	No
7. Muscle or Neuromuscular diseases such as muscular dystrophy?	Yes	No	Yes	No
8. Hemophilia?	Yes	No	Yes	No
9. Kidney disorders?	Yes	No	Yes	No
10. Huntington's disease?	Yes	No	Yes	No
11. Three or more miscarriages?	Yes	No	Yes	No
12. A child that died during infancy or childhood?	Yes	No	Yes	No
13. Any birth defect or genetic disease not listed above?	Yes	No	Yes	No

If you have answered yes to any of the above questions, please state how the affected individual is related to you and any known details about their condition: