

# Genetic Screening Questionnaire

Fertility and Reproductive Medicine Center  
Washington University Physicians and Barnes-Jewish Hospital

Patient's First & Last Name

Patient Date of Birth

Partner's First & Last Name (if applicable)

Partner Date of Birth

*This questionnaire is designed to identify risk factors in your personal or family history that may impact your reproductive risks. The questions will enable us to determine whether you may benefit from additional testing or genetic counseling. All answers will be kept confidential.*

*Please note that no questionnaire can be comprehensive so if you have specific concerns about your/your partner's personal medical history or family history, please make your physician aware.*

1. Please indicate your ancestry/ethnicity (check all that apply):

Patient:

- |   |   |   |
|---|---|---|
| <input type="checkbox"/> Ashkenazi Jewish           | <input type="checkbox"/> Asian                    | <input type="checkbox"/> Black/African American |
| <input type="checkbox"/> French Canadian/Cajun      | <input type="checkbox"/> Hispanic/Latino          | <input type="checkbox"/> Mediterranean          |
| <input type="checkbox"/> Middle Eastern             | <input type="checkbox"/> Native American          | <input type="checkbox"/> Pacific Islander       |
| <input type="checkbox"/> White/European             | <input type="checkbox"/> Sephardic/Mizrahi Jewish | <input type="checkbox"/> Unknown                |
| <input type="checkbox"/> Other (please list): _____ |   |   |

Partner:

- |   |   |   |
|---|---|---|
| <input type="checkbox"/> Ashkenazi Jewish           | <input type="checkbox"/> Asian                    | <input type="checkbox"/> Black/African American |
| <input type="checkbox"/> French Canadian/Cajun      | <input type="checkbox"/> Hispanic/Latino          | <input type="checkbox"/> Mediterranean          |
| <input type="checkbox"/> Middle Eastern             | <input type="checkbox"/> Native American          | <input type="checkbox"/> Pacific Islander       |
| <input type="checkbox"/> White/European             | <input type="checkbox"/> Sephardic/Mizrahi Jewish | <input type="checkbox"/> Unknown                |
| <input type="checkbox"/> Other (please list): _____ |   |   |

2. Have you or your partner ever had genetic testing such as carrier screening or a karyotype (chromosome analysis)?

☐ Self    ☐ Partner    ☐ Neither

If yes, explain and please provide a copy of the test report(s) to our office: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**Fertility and Reproductive Medicine Center**  
Suite 3100, 4444 Forest Park Ave., St. Louis, MO 63108  
Phone: (314) 286-2465 • Fax: (314) 286-2455



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3. Do you or your partner have a known genetic condition or chromosome abnormality such as a translocation?

☐ Self      ☐ Partner      ☐ Neither

If yes, explain and please provide a copy of the test report(s) to our office: \_\_\_\_\_

4. Have you or your partner ever had more than two miscarriages (together or with a different partner) or any stillbirth (pregnancy loss after 20 weeks gestation)?

☐ Self      ☐ Partner      ☐ Neither

5. Are you and your partner biologically related to one another?

☐ Yes, relationship: \_\_\_\_\_ ☐ No

6. Do you, your partner, or any family member (e.g. children, parents, brothers, sisters, nieces, nephews, aunts, uncles, or grandparents) have any of the following conditions? If yes, please provide details and, if available, genetic test results.

Condition	Yes	No	Details (affected individual, age diagnosed, etc.)
Intellectual disability/developmental delay			
Autism			
Heart defect present at birth			
Cleft lip or palate			
Neural tube defect (e.g. spina bifida, anencephaly)			
Limb anomaly (e.g. extra/missing fingers, abnormality of arms, legs, hands, feet)			
Other birth defect			
Hearing loss/deafness before age 60			
Serious eye conditions or blindness			
Hemophilia or other blood disorder (e.g. bleeding or clotting abnormalities)			
Alpha or beta thalassemia			
Sickle cell anemia or sickle cell trait			
Cystic fibrosis (CF) or CF carrier			
Spinal muscular atrophy (SMA)			
Tay-Sachs disease			
Polycystic kidney disease			
Neurofibromatosis type 1 or 2			
Seizures/epilepsy			

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Condition	Yes	No	Details (affected individual, age diagnosed, etc)
<b>Muscular dystrophy (e.g. Duchenne, myotonic) or other neuromuscular disease</b>			
<b>Skeletal dysplasia or dwarfism</b>			
<b>Huntington's disease</b>			
<b>Hereditary cancer syndrome (e.g. BRCA1/2 or Lynch syndrome)</b>			
<b>Cancer diagnosed less than age 50</b>			
<b>Chromosome translocation or other chromosome condition (e.g. Down syndrome)</b>			
<b>Known carrier of a genetic condition</b>			

7. Do you or your partner have concerns about any other health conditions in either of your families not listed above?  
☐ Yes, explain: \_\_\_\_\_ ☐ No

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