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:

☐ Ashkenazi Jewish	☐ Asian	☐ Black/African American
☐ French Canadian/Cajun	☐ Hispanic/Latino	☐ Mediterranean
☐ Middle Eastern	☐ Native American	☐ Pacific Islander
☐ White/European	☐ Sephardic/Mizrahi Jewish	☐ Unknown

☐ Other (please list): _____

Partner:

☐ Ashkenazi Jewish	☐ Asian	☐ Black/African American
☐ French Canadian/Cajun	☐ Hispanic/Latino	☐ Mediterranean
☐ Middle Eastern	☐ Native American	☐ Pacific Islander
☐ White/European	☐ Sephardic/Mizrahi Jewish	☐ Unknown

☐ 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 your 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)
Muscular dystrophy (e.g. Duchenne, myotonic) or other neuromuscular disease			
Skeletal dysplasia or dwarfism			
Huntington's disease			
Hereditary cancer syndrome (e.g. BRCA1/2 or Lynch syndrome)			
Cancer diagnosed less than age 50			
Chromosome translocation or other chromosome condition (e.g. Down syndrome)			
Known carrier of a genetic condition			

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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