Genetic Screening Questionnaire

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

Patient's Name ______________________ Date of Birth ______________

Today's Date ______________

The following questions will enable us to determine whether certain tests may be appropriate in helping to complete a preconception genetic health evaluation. All information will be kept confidential.

This questionnaire is designed to identify potential genetic issues that may have relevancy to future offspring. If you have particular concerns about other conditions in your family (cancer, heart disease, diabetes, etc.), please make your physician aware of your concerns.

1. What are your ethnic origins (English, German, Italian, African, etc.)?

2. What are your partner's ethnic origins?

3. Are you OR your partner Jewish or French Canadian? ❑ Yes ❑ No

   If yes, have either of you been tested for Tay-Sachs disease? ❑ Yes ❑ No
   If yes, indicate who and the results:

4. Are you OR your partner African-American (Black) or Latino? ❑ Yes ❑ No

   If yes, have either of you been tested for sickle cell disease/trait? ❑ Yes ❑ No
   If yes, indicate who and the results:

5. Are you OR your partner Italian, Greek, Mediterranean, Middle Eastern, or Asian (from SE Asia, China, Taiwan, Philippines, India)? ❑ Yes ❑ No

   If yes, have either of you been tested for thalassemia? ❑ Yes ❑ No
   If yes, indicate who and the results:

6. Have you OR your partner had any children (living or dead) with a birth defect, mental retardation or serious health problem (include any children from you and/or your partner's previous relationships/marriages)? ❑ Yes ❑ No
   If yes, please explain:

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7. Were you OR your partner born with any birth defects (congenital heart defect, cleft palate, etc.) or do you have any serious health problems? ❑ Yes ❑ No
   If yes, please explain:

8. Does/did anyone in either your or your partner's family have any of the following?
   Please include yourself, your partner, your children, your parents, brothers, sisters, nieces, nephews, aunts, uncles, and grandparents:

	Yes	No	If yes, who?
Mental retardation, learning disability, or autism	❑	❑	
Down syndrome or other chromosome abnormality	❑	❑	
Born with a heart defect	❑	❑	
Born with cleft lip or palate	❑	❑	
Born with a neural tube defect (open spine, spina bifida or anencephaly)	❑	❑	
Born with extra/missing fingers or toes or abnormality of arms, legs, hands or feet	❑	❑	
Hearing problems or deafness (before age 60)	❑	❑	
Serious eye problems or blindness	❑	❑	
Hemophilia or a bleeding disorder	❑	❑	
Neuromuscular disease or muscular dystrophy	❑	❑	
Huntington disease	❑	❑	
Cystic Fibrosis	❑	❑	
Sickle Cell Disease	❑	❑	
Three or more miscarriages and/or stillbirths	❑	❑	
Seizures or epilepsy	❑	❑	

9. Do you, your partner, or anyone in either of your families have a birth defect, inherited disorder, or chromosome abnormality not listed above? ❑ Yes ❑ No
   If yes, indicate condition(s) and person(s) affected:

10. Do you or your partner have concerns about any other conditions in either of your families? ❑ Yes ❑ No
    If yes, please explain:

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