CHICAGO women's HEALTH GROUP

Genetic Screening Questionnaire

Name: _____ Date: _____

Instructions: Please answer the following questions to the best of your ability. Your healthcare provider will review the information given at your visit. Thank you.

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

2. Age of father/sperm donor of the child? _____

3. What is your ethnicity/ancestry?

- ☐ Ashkenazi Jewish
- ☐ Asian
- ☐ Black/African American
- ☐ French Canadian
- ☐ Hispanic/Latinx
- ☐ Mediterranean
- ☐ Native American or Alaska Native
- ☐ Pacific Islander or Native Hawaiian
- ☐ Sephardic Jewish
- ☐ White/Caucasian
- ☐ Other _____

4. What is the ethnicity/ancestry of the father/sperm donor?

- ☐ Ashkenazi Jewish
- ☐ Asian
- ☐ Black/African American
- ☐ French Canadian
- ☐ Hispanic/Latinx
- ☐ Mediterranean
- ☐ Native American or Alaska Native
- ☐ Pacific Islander or Native Hawaiian
- ☐ Sephardic Jewish
- ☐ White/Caucasian
- ☐ Other _____

5. Do you have any religious reasons that you cannot receive blood products/transfusions? ☐ Yes ☐ No

6. Have you, the baby's father, or anyone in either of your families ever had any of the following disorders:

- Neural Tube Defect, i.e., Spina Bifida (myelomeningocele or open spine), anencephaly ☐ Yes ☐ No
- Congenital Heart Defect ☐ Yes ☐ No
- Down Syndrome ☐ Yes ☐ No
- Tay-Sachs ☐ Yes ☐ No
- Canavan Disease ☐ Yes ☐ No
- Sickle Cell Disease ☐ Yes ☐ No
- Hemophilia ☐ Yes ☐ No
- Muscular Dystrophy ☐ Yes ☐ No
- Cystic Fibrosis ☐ Yes ☐ No

7. Do you or the baby's father have any close relatives with intellectual disability or autism? ☐ Yes ☐ No

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8. Do you or the baby's father have any close relatives with Fragile X? ☐ Yes ☐ No

9. Do you or the baby's father have diabetes, metabolic syndrome, celiac disease, PKU, or any other disorder that prevents you from metabolizing food without assistance? ☐ Yes ☐ No

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

11. In this or any previous relationships, have you or the baby's father had a stillborn child or three or more first-trimester spontaneous pregnancy losses? ☐ Yes ☐ No

12. Have you ever had chicken pox? ☐ Yes ☐ No

13. Have you or the baby's father ever had or been treated for a sexually transmitted disease, such as chlamydia, herpes, gonorrhea, syphilis? ☐ Yes ☐ No

14. Have you or the baby's father ever had a positive test for HIV or been exposed to AIDS? ☐ Yes ☐ No

15. Have you ever had or tested positive for tuberculosis? ☐ Yes ☐ No

16. Are you and the baby's father related (besides marriage)? ☐ Yes ☐ No

17. Have you or the baby's father ever had hepatitis? ☐ Yes ☐ No

18. Do you work in the healthcare field? ☐ Yes ☐ No

19. Do you have cats? ☐ Yes ☐ No

20. Do you garden? ☐ Yes ☐ No

21. Have you traveled outside the country during pregnancy? ☐ Yes ☐ No

22. Have you had gestational diabetes in a previous pregnancy? ☐ Yes ☐ No

23. Have you taken any prescribed medications, over-the-counter medications, recreational drugs, or alcohol since your last menstrual period? If yes, please list medication and dose. ☐ Yes ☐ No

_____

_____

24. Have you had any previous pregnancies with a different practice? ☐ Yes ☐ No

If yes: _____

Date of delivery: _____

How many weeks when delivered: _____

Vaginal or Caesarean section: _____

Weight of baby: _____

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PATIENT HEALTH QUESTIONNAIRE (PHQ-9)

Name: _____ Date: _____

	Not at all	Several days	More than half the days	Nearly every day
1. Little interest or pleasure in doing things	0 ☐	1 ☐	2 ☐	3 ☐
2. Feeling down, depressed, or hopeless	0 ☐	1 ☐	2 ☐	3 ☐
3. Trouble falling or staying asleep, or sleeping too much	0 ☐	1 ☐	2 ☐	3 ☐
4. Feeling tired or having little energy	0 ☐	1 ☐	2 ☐	3 ☐
5. Poor appetite or overeating	0 ☐	1 ☐	2 ☐	3 ☐
6. Feeling bad about yourself or that you are a failure or have let yourself or your family down	0 ☐	1 ☐	2 ☐	3 ☐
7. Trouble concentrating on things, such as reading the newspaper or watching television	0 ☐	1 ☐	2 ☐	3 ☐
8. Moving or speaking so slowly that other people could have noticed. Or the opposite: being so fidgety or restless that you have been moving around a lot more than usual.	0 ☐	1 ☐	2 ☐	3 ☐
9. Thoughts that you would be better off dead, or of hurting yourself	0 ☐	1 ☐	2 ☐	3 ☐

(Healthcare professional: For interpretation of TOTAL, please refer to accompanying scoring card)

add columns _____ + _____ + _____

Total Score _____

10. If you checked off any problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?	Not difficult at all _____ Somewhat difficult _____ Very difficult _____ Extremely difficult _____

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