University of Maryland Medical Center
Ob/Gyn Department

PRENATAL DIAGNOSIS SCREENING QUESTIONNAIRE

PATIENT IDENTIFICATION

Please complete the questionnaire and bring with you to your appointment. *CHECK YES or NO*. Check any question you do not understand. If you answer *yes* to any questions marked with an asterisk (✱), please call our office so we may obtain further information before you are seen.

		YES	NO
1.	Will you be age 35 or older when the baby is due?	____	____
2.	Since you became pregnant, have you used or taken:		
	a. Medications	____	____
	b. Insulin (shots for Diabetes)	____	____
✱	c. Seizure medications	____	____
	d. Drugs	____	____
	e. Alcohol	____	____
	Cigarettes	____	____
3.	Since you became pregnant, have you had any:		
	a. Infections	____	____
	b. Rashes	____	____
	c. High fevers	____	____
	d. X-rays	____	____
4.	Have you or the baby's father ever had an illness, sickness or birth defect which required medical care, staying in the hospital, or surgery/operations?	____	____
5.	Are you and the baby's father related by blood (for example, are you distant cousins)?	____	____

6. Are you or the baby's father:

[ ] Jewish	[ ] Black	[ ] Mediterranean
[ ] Asian	[ ] Italian	[ ] Greek

		YES	NO
7.	Do you or does the father of the baby, or does anyone in *either families* have:	____	____
✱	a. Mental retardation	____	____
	b. Slow or learning disability	____	____
	c. Birth defect or handicap	____	____
	d. Stillbirth or baby born dead	____	____
	e. Early infant death	____	____
	f. Two(2) or more miscarriages or pregnancy losses	____	____
✱	g. An inherited or genetic disease	____	____
	h. Down syndrome ("mongolism")	____	____
	i. Spinal bifida or open spine	____	____
	j. Hydrocephalus (water on the brain)	____	____
✱	k. Muscular dystrophy or muscle disorder	____	____
	l. Wheelchair bound	____	____
✱	m. Hemophilia or bleeding disorder	____	____

		YES	NO
✱	n. Sickle cell anemia	______	______
✱	o. Cystic fibrosis	______	______
✱	p. PKU	______	______
✱	q. Huntington's disease	______	______
	r. Deafness	______	______
	s. Blindness	______	______
	t. Kidney problems	______	______

8. Is there anything else in your family or the baby's father's family that you are worried about? ______ ______

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PATIENT'S SIGNATURE ______________________________

DATE ______________________________