

## NACOGDOCHES WOMEN'S CENTER 4710 N.E. STALLINGS DR. NACOGDOCHES, TX 75965

## **OB/GYN GENETIC SCREENING FORM**

1. Patient's Name:		
Last	First	Maiden
Birth Date:	Age:	
Home Phone:	Work Phone:	
Name of the Father of the Child:		
Last	First	Maiden
Birth Date:	Age:	
2. Pregnancy History:		
Number of Pregnancies: Number of Miscarriages/Abortions:		Number of Stillbirths:
Delivery Dates (living and decease	d):	
Sex:	Birth Weight:	
Health Status:		
Was father different from above? _		
3. Are you and the father of this pre	eanancy blood relatives?	
4. Are there inherited disorders, or opregnancy? If yes, list:	,	



	_	e the type of medical care you prefer to receive? For
•	father identify within on d answer the correspond	e or more of the following demographics, please circle ding questions.
		nily members had the diagnosis of Sickle Cell Anemia or rrier test?
		nily members had Tay-Sachs carrier testing, or have any
·	-	nily members had any form of Thalassemia or had
7. Please list any med	dicines (prescription or o	ver the counter) taken since becoming pregnant:
Do you use any drug	s (street, illegal, recreation	onal) not listed above? If yes, please list:
Have you been expo yes, please list:	osed to any x-rays, chem	nicals, or environmental hazards since this pregnancy? If
in the families of either at the bottom of this bring any medical re	er of you (parents, childr sheet IN DETAIL all inforn	er disorders, occurred in you or the father of this child or ren, sisters, brothers, and descendants)? Please provide nation on ANY disorder you check. If possible, please occurrence of this disorder. If there is no family history of and your initials
Infant or Childho Stillbirths Mental Retardat	tion	Spina Bifida (open spine) Anencephaly Hydrocephaly (water on the brain) Sickle Cell Anemia or Trait



Tay-Sachs Disease or Carrier	Congenital Heart Disease/Defect
Thalassemia	Blindness
Cystic Fibrosis	Deafness
Galactosemia	Polycystic Kidney Disease
Phenylketonuria (PKU)	Any Skeletal (bone) Disorder
Hemophilia or Bleeding Disorder	Dwarfism (short stature)
Muscular Dystrophy or any Muscle	Multiple Miscarriages
Disorder	Enzyme or Metabolic Disease
Birth Defects (list below)	Other known or suspected inherited or
Huntington's Chorea	genetic conditions:
Acute Intermittent Porphyria	
Cleft Lip or Palate	
Have you ever had any blood transfusions?  10. Do you currently or have you ever had a viral	
11. Do you have any other concerns or history no	t covered above? YES NO
IF ANY OF YOUR RESPONSES IN THIS FORM WERE "Y PROVIDE THE MEDICAL DETAILS BELOW IN DETAIL:	YES", EXPLAIN WHO IN THE FAMILY IS AFFECTED AND
Signature of Patient:	Date: