Earle Oki, MD
A Professional Corporation

GENETIC FAMILY HISTORY & PREGNANCY QUESTIONNAIRE

Date of Appointment _____

Section 1. Patient Information

Name _____ Date of Birth _____ Occupation _____

Address _____ City _____ State Nevada ZIP _____

Home Phone _____ Work Phone _____ Cell Phone _____

Referring Physician's Name _____ Referring Physician's Phone Number _____

Section 2. Partner Information (If patient is pregnant, then "partner" is the father of the pregnancy)

Name _____ Date of Birth _____ Occupation _____

The following questions will help your genetic counselor complete a genetic risk assessment and determine if certain tests are appropriate. If you are unsure about your family history, please speak with family members.

Section 3. Are you or your partner from any of these ethnic backgrounds?

Please check all that apply

	Patient	Partner
Chinese, Taiwanese, Asian Indian, Pakistani, Filipino, or Southeast Asian	☐	☐
Italian, Greek, Middle Eastern, Spanish or Portuguese	☐	☐
Jewish, French, Canadian or Cajun	☐	☐
African American, African descent, Black, Puerto Rican, Carribbean or Central American.	☐	☐
Hispanic or Mexican	☐	☐
Caucasian	☐	☐
Other (specify) _____	☐	☐

Section 4. Have you, your partner, or anyone in your families ever had the following conditions:

	Yes	No		Yes	No
Down Syndrome	☐	☐	polycystic kidney disease	☐	☐
other chromosome problem	☐	☐	Huntington disease	☐	☐
mental retardation or autism	☐	☐	heart defect at birth	☐	☐
spina bifida (open spine)	☐	☐	cleft lip/cleft palate	☐	☐
anencephaly (opening in head/brain)	☐	☐	blindness/deafness	☐	☐
blood disorder, such as hemophilia or sickle cell	☐	☐	baby who died after birth or within first year	☐	☐
muscular dystrophy or neuromuscular disease	☐	☐	stillborn or 2 or more pregnancy losses	☐	☐
Cystic fibrosis	☐	☐	any birth defect not listed above	☐	☐
neurofibromatosis.	☐	☐	any other inherited genetic condition	☐	☐
skeletal disorder, like dwarfism	☐	☐	any other serious meidcal condition or surgery	☐	☐

Are you or your partner adopted?	☐	☐
Are you and your partner related to each other - other than by marriage?	☐	☐
Is there a history of infertility in either you and/or your partner?	☐	☐
Please specify the cause of infertility, if known. _____		
Have you and/or your partner had carrier testing for cystic fibrosis?	☐	☐
Have you and/or your partner had carrier testing for any other genetic disorder?	☐	☐
Have you and/or your partner had blood chromosome testing?	☐	☐

Please explain any "Yes" answers from Section 4

Section 5. Please complete the following patient information:

	Yes	No		Yes	No
current medications Please list: _____	☐	☐	Do you have diabetes, PKU or lupus?	☐	☐
recreational drugs	☐	☐	Are you considering or have you used:		
alcoholic drinks	☐	☐	egg donor or donor sperm	☐	☐
cigarette smoking	☐	☐	preimplantation genetic diagnosis (PGD)	☐	☐
			intracytoplasmic sperm injection (ICSI)	☐	☐

Please explain any "Yes" answers from Section 5

Section 6. If you are currently pregnant, have you had any of the following: Due Date: _____

	Yes	No		Yes	No
rashes, infections, fevers	☐	☐	Have you had maternal serum screening? (such as AFP blood screen, AFP3, AFP4, triple marker screen, first trimester screen)	☐	☐
spotting, bleeding or any other complications	☐	☐			
exposure to x-rays	☐	☐			

Please explain any "Yes" answers from Section 6

I have answered these questions to the best of my knowledge. _____ _____

Patient's Signature Date

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