EVERGREEN HOSPITAL MEDICAL CENTER

Patient Sticker

Eastside MATERNAL FETAL MEDICINE

Date _____

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

Please circle and check all that apply

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

Section 2. 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, autism, developmental delay	☐	☐	heart defect at birth	☐	☐
spina bifida (open spine)	☐	☐	cleft lip/cleft palate	☐	☐
anencephaly (open head/brain)	☐	☐	blindness / deafness	☐	☐
cystic fibrosis (a lung disease)	☐	☐	blood disorder, such as hemophilia or sickle cell	☐	☐
muscular dystrophy or neuromuscular disease	☐	☐	stroke or blood clot at age less than 50	☐	☐
skeletal disorder, like dwarfism	☐	☐	any other birth defect/genetic/inherited condition	☐	☐
neurofibromatosis	☐	☐	any other serious medical condition or surgery	☐	☐

	Yes	No
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 or any other genetic disorder?	☐	☐
Have you and/or your partner had blood chromosome testing?	☐	☐
Have you or your partner (with a previous partner) ever had a miscarriage, stillbirth or infant death?	☐	☐
If yes, how many times?_____ How many weeks/months along was/were the pregnancies?_____		
Have you ever had a pregnancy with growth restriction (IUGR)?	☐	☐
Have you ever had a baby born small for its age, or that the doctors delivered early because it was small?	☐	☐

Section 3. Please complete the following patient information:

	Yes	No		Yes	No
Are you currently pregnant?	☐	☐	Since you have been pregnant:		
If yes, what is your due date?_____			have you taken any medication?	☐	☐
If yes, was this pregnancy achieved with IVF?	☐	☐	Please list:_____		
In this pregnancy, have you used or are you considering:			had any alcoholic drinks?	☐	☐
donor egg (age of donor____) or donor sperm?	☐	☐	smoked any cigarettes?	☐	☐
preimplantation genetic diagnosis/screening (PGD/PGS)	☐	☐	used any recreational drugs?	☐	☐
intracytoplasmic sperm injection (ICSI)	☐	☐	had any rashes, infections, fevers?	☐	☐
Do you have diabetes, PKU or lupus?	☐	☐	had exposure to any x-rays (other than dental)?	☐	☐

	Yes	No
Have you had any of the following: maternal serum screening, AFP blood test, triple marker screen, quad screen, first trimester screen, sequential screen, integrated screen?	☐	☐

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

Patient's signature Date

If "yes" response or ethnicity screening indicated, genetic counseling was offered:

I accept genetic counseling _____ I decline genetic counseling _____

Patient's Initials Patient's Initials

_____

MD/GC