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## Genetics Questionnaire

Name: \_\_\_\_\_ DOB: \_\_\_\_\_ Date: \_\_\_\_\_

- 1.) Will you be age 34 or older when the baby is due? Yes \_\_\_\_\_ No \_\_\_\_\_
  - a. Age when due? \_\_\_\_\_
- 2.) Have you, the baby's father or anyone in either of your families ever had:
  - a. Down Syndrome Yes \_\_\_\_\_ No \_\_\_\_\_
  - b. Spina Bifida or Meninquocele Yes \_\_\_\_\_ No \_\_\_\_\_
  - c. Hemophilia Yes \_\_\_\_\_ No \_\_\_\_\_
  - d. Muscular Dystrophy Yes \_\_\_\_\_ No \_\_\_\_\_
  - e. Cystic Fibrosis Yes \_\_\_\_\_ No \_\_\_\_\_
  - f. Huntington's Chorea Yes \_\_\_\_\_ No \_\_\_\_\_
  - g. Blood Disorders Yes \_\_\_\_\_ No \_\_\_\_\_
- 3.) Have you or the baby's father had a child born dead or alive with a birth defect not listed in the above question? Yes \_\_\_\_\_ No \_\_\_\_\_
  - a. If yes, please describe: \_\_\_\_\_
- 4.) Do you or the baby's father have any close relatives who are developmentally delayed? Yes \_\_\_\_\_ No \_\_\_\_\_
  - a. If yes, please describe; \_\_\_\_\_
- 5.) Do you, the baby's father or any close relatives in either of your families have an inherited genetic or chromosomal disease or disorder not listed above? Yes \_\_\_\_\_ No \_\_\_\_\_
  - a. If yes, please describe: \_\_\_\_\_
- 6.) Have you, or the partner of this baby's father from a previous relationship, had three or more spontaneous pregnancy losses? Yes \_\_\_\_\_ No \_\_\_\_\_
- 7.) Do you or the baby's father have any close relatives descended from Jewish people who live in Eastern Europe (Ashkenazi Jews)? Yes \_\_\_\_\_ No \_\_\_\_\_
- 8.) If you or your partner are African American, have you, the baby's father or any close relatives been screened for Sickle Cell trait and found to be positive? Yes \_\_\_\_\_ No \_\_\_\_\_