

Lufkin Women's Center

OBSTETRICS, GYNECOLOGY & INFERTILITY

LUFKIN WOMEN'S CENTER
102 WESTSIDE MEDICAL BLVD.
LUFKIN, TX 75904

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 Livebirths: _____ Number of Stillbirths: _____

Number of Miscarriages/Abortions: _____

Delivery Dates (living and deceased):

Sex: _____ Birth Weight: _____

Health Status: _____

Was father different from above? _____

3. Are you and the father of this pregnancy blood relatives? _____

4. Are there inherited disorders, or any birth defects, in the families of you or of the father of this pregnancy? If yes, list:

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5. Do you have any belief that would change the type of medical care you prefer to receive? For example, are you a Jehovah's Witness? _____

6. If you or the child's father identify within one or more of the following demographics, please circle which may apply and answer the corresponding questions.

Black Indian Eastern Mediterranean

Have you and/or the child's father or any family members had the diagnosis of Sickle Cell Anemia or Sickle Cell Trait or had Sickle Cell Anemia Carrier test? _____

Jewish

Have you and/or the child's father or any family members had Tay-Sachs carrier testing, or have any family members had Tay-Sachs disease? _____

Italian Greek Asian African

Have you and/or the child's father or any family members had any form of Thalassemia or had Thalassemia carrier testing? _____

7. Please list any medicines (prescription or over the counter) taken since becoming pregnant:

Do you use any drugs (street, illegal, recreational) not listed above? If yes, please list:

Have you been exposed to any x-rays, chemicals, or environmental hazards since this pregnancy? If yes, please list:

8. Have any of the following disorders, or other disorders, occurred in you or the father of this child or in the families of either of you (parents, children, sisters, brothers, and descendants)? Please provide at the bottom of this sheet IN DETAIL all information on ANY disorder you check. If possible, please bring any medical records documenting the occurrence of this disorder. If there is no family history of birth defects or disorders, please list "NONE" and your initials. _____

____ Infant or Childhood Deaths

____ Stillbirths

____ Mental Retardation

____ Downs Syndrome (mongolism)

____ Spina Bifida (open spine)

____ Anencephaly

____ Hydrocephaly (water on the brain)

____ Sickle Cell Anemia or Trait

____ Tay-Sachs Disease or Carrier

____ Thalassemia

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- | | |
|--|--|
| <input type="checkbox"/> Cystic Fibrosis | <input type="checkbox"/> Blindness |
| <input type="checkbox"/> Galactosemia | <input type="checkbox"/> Deafness |
| <input type="checkbox"/> Phenylketonuria (PKU) | <input type="checkbox"/> Polycystic Kidney Disease |
| <input type="checkbox"/> Hemophilia or Bleeding Disorder | <input type="checkbox"/> Any Skeletal (bone) Disorder |
| <input type="checkbox"/> Muscular Dystrophy or any Muscle Disorder | <input type="checkbox"/> Dwarfism (short stature) |
| <input type="checkbox"/> Birth Defects (list below) | <input type="checkbox"/> Multiple Miscarriages |
| <input type="checkbox"/> Huntington's Chorea | <input type="checkbox"/> Enzyme or Metabolic Disease |
| <input type="checkbox"/> Acute Intermittent Porphyria | <input type="checkbox"/> Other known or suspected inherited or genetic conditions: |
| <input type="checkbox"/> Cleft Lip or Palate | _____ |
| <input type="checkbox"/> Congenital Heart Disease/Defect | _____ |

9. Do you have reason to believe that you have been exposed to AIDS? YES NO
Have you ever had any blood transfusions? YES NO

10. Do you currently or have you ever had a viral infection known as herpes? YES NO

11. Do you have any other concerns or history not covered above? YES NO

IF ANY OF YOUR RESPONSES IN THIS FORM WERE "YES", EXPLAIN WHO IN THE FAMILY IS AFFECTED AND PROVIDE THE MEDICAL DETAILS BELOW IN DETAIL:

Signature of Patient: _____

Date: _____